MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 15, 2011
9:09 a.m.

COMMISSIONERS PRESENT:
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AGENDA PAGE

P R O C E E D I N G S [9:09 a.m.]

MR. HACKBARTH: Okay. It's time for us to get started. At this meeting we will be considering draft recommendations for updates for each of the provider sectors within the Medicare program. These are draft recommendations. We will have final votes in January. The recommendations could change as a result of the discussion that occurs today. And then, of course, our final recommendations after the January votes will be included in our March report to Congress.

Before we begin talking about hospitals, I wanted to say a word for the audience about how we approached this task and the implications of the sequester envisioned under the debt ceiling legislation would affect our deliberations.

Our basic approach to consideration of updates is to assume as a starting point no change in the base rate that applies to a given group of providers, whether it be hospitals or skilled nursing facilities or home health agencies. So if you think in terms of how the Medicare system works, checks are sent out and the core base calculation in the amount paid to a provider for a given service, it starts with a base rate that is then modified by

a series of factors like wage indices and case mix adjustments, but the case mix drives the level of the payment for each of the provider payment systems.

When MedPAC thinks about updating the rates, it's thinking about those base rates, and we will express our recommendations in terms of a percentage change up or down in those base rate calculations.

We do not use formulas like market basket minus productivity or market basket plus some factor. We express our recommendations in terms of percentage changes in the base rate.

Our analytic framework assumes zero as the starting point -- in other words, no change in the base rate as the starting point. Then we examine the evidence, our payment adequacy indicators, and use that evidence to make a judgment that the rate either should go higher or lower by some percentage amount. But the starting point for the analysis is no change in the base rate.

So what is the effect of the potential sequester on Medicare? First of all, the sequester under the Budget Control Act would take effect in February of 2013. The recommendations we are making in our March report are for

fiscal year 2013. So the sequester would actually take effect partway through the fiscal year in question.

The official determination on whether there will be a sequester or not does not happen until January of 2013. So while there is a distinct possibility of a sequester beginning in February 2013, it has not been officially determined at this point.

MedPAC will make our recommendations for a percentage change in the base rates. If there is, in fact, a decision on a sequester at a later point, what that would effect is the budget impact of MedPAC's recommendations. And if you look at this slide, it provides a simple example of how this would work with no-sequester or sequester scenarios.

The important point from our perspective is we are making the same 1-percent recommendation for an increase in the base rates, and where the effect of the sequester shows up is on the bottom line, and that is how CBO would score the effect of that 1 percent. If there is no sequester, it might be scored as a savings compared to current law. If there is, in fact, a sequester, it might be scored as a cost relative to current law.

So when we go through our discussion over the next couple days, you will not hear us talking about the sequester item by item. We will go through our basic analysis, how much should the base rates change, plus or minus. The sequester is in the background. It modifies the scoring of our recommendations and only the scoring.

So I hope that helped clarify things at least a little bit.

For those of you in the press who are writing stories about this, if you need additional clarification, you can talk to Arielle, and she'll walk you through the specifics.

So our first session today is on payment adequacy for hospital inpatient and outpatient services.

DR. STENSLAND: Good morning. This session will address issues regarding Medicare payments to hospitals. There are three topics to cover today.

The first is the overall payment adequacy. We will discuss whether Medicare payment rates are adequate and the Chairman's draft recommendation for updating hospital payments.

Second, as part of PPACA, we are required to

examine rural payment adequacy. In this session we will discuss rural hospital payments and costs. The analysis for other sectors will occur later today where they will also discuss the adequacy of rural payments in each sector. Then in January, I will come back to summarize the different payment adequacy findings for all the different sectors in one general overview of rural payment adequacy. The information on rural payment adequacy will eventually be part of the broader rural report which is due in June of 2012.

Third, we will discuss the payment rates for E&M visits that take place in hospital outpatient departments compared to rates paid for E&M visits in free-standing offices. The objective is to make sure we are paying equally across sectors when the complexity of the service and the quality of the service don't differ.

To evaluate payment adequacy, we use a common framework across all the sectors. When data is available, we examine capacity, service volume, quality of care, access to capital, as well as providers' costs and payments for Medicare services. When we discuss profit margins, we will present margins for the average hospital, for relatively

efficient hospitals, and for rural providers.

This is the first set of payment adequacy discussions you will hear today. The analysts discussing payment adequacy for other sectors later will use this same set of indicators when data is available.

There is a lot to cover, so I am going to go fairly quickly. There is much more detailed information 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. We also discuss the distribution of payments across categories of hospitals and across categories of different services.

In 2010 Medicare spent roughly $153 billion on traditional inpatient and outpatient fee-for-service payments. This represents a 3.5-percent increase in spending per beneficiary. The 3.5-percent growth rate primarily reflects three factors: first, a 2-percent payment update; second, a small increase due to continued documentation and coding changes, as we will discuss later; and, third, growth in the volume of outpatient care.

Last month Zach discussed how capacity was increasing and how access to capital is adequate. We see strong volume growth in outpatient services and a slight decline in inpatient volume. These capacity and volume measures, particularly the growth in outpatient volumes, point to adequate payments.

All quality-of-care indicators are either improving or stable. We see improvements in the 30-day mortality for conditions we monitor including AMI, congestive heart failure, stroke, hip fracture, and pneumonia. There has also been some improvement in patient safety and patient satisfaction measures.

However, readmission rates have not improved. In the past, the Commission recommended financial incentives to spur improvements in the readmission rates. CMS will start readmission penalties in 2013.

Given the challenge of program sustainability, one positive finding from 2010 was that hospitals were able to slow their cost growth while their quality metrics either improved or remained stable. Craig will now explain how 2010 payments and costs changed in detail.

MR. LISK: Good morning. In assessing payment

adequacy, we consider the relationship between Medicare payments for and hospitals' costs of furnishing care to Medicare patients. Growth in Medicare hospital payments per discharge under the IPPS depends primarily on three factors: annual payment updates, changes in reported case mix, and policy changes that are not implemented in a budget-neutral manner.

In 2010, hospitals received a 2.1-percent payment update for operating rates. Inpatient payments per case, however, increased 2.5 percent, about 0.5 percentage points more than the update. Per case payments increased faster than the update in 2010 primarily due to increases in reported case mix due to documentation and coding changes.

Now let's shift focus to cost growth. A combination of low input price inflation and financial pressure on hospitals resulted in a continued slowing of hospital cost growth in 2010. Medicare inpatient costs per case rose only 2 percent in 2010, down from 2.9 percent in 2009. This is the slowest rate of increase since 1998. The lower cost growth in 2010 was partly due to lower input price inflation facing hospitals, which increased by 2.1 percent in 2010, the lowest rate of increase in input prices

in over a decade. Hospitals may also have worked to control cost growth in response to the recession and the difficult year they had financially in 2008, when the industry experienced historically low total all-payer margins and had steep declines in their balance sheets.

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. And you'll see this is the measure we'll be using across all other sectors, too.

Now, the overall Medicare margin covers acute inpatient services, outpatient services, hospital-based home health, skilled nursing facility, and inpatient psychiatric and rehabilitation services in hospitals covered by the inpatient prospective payment system, as well as graduate medical education.

Because payments grew faster than costs, we see an improvement in the 2010 overall Medicare margin from minus 7.1 percent in 2008 to minus 4.5 percent in 2010. The increase was driven by improvements in margins for both inpatient and outpatient care, which comprise the bulk of the services included in the overall Medicare margin.

The improvement in inpatient and overall margins in 2009 was primarily due to increases in reported case mix from documentation and coding changes. The increase in 2010 was primarily due to lower cost growth and continued increases in reported case mix for inpatients from documentation and coding. Outpatient margins improved due to increases in the volume of outpatient services and cost growth being constrained below the hospital updates in 2010.

Our next slide shows how the overall Medicare margins differs across hospital groups.

Major teaching hospitals continue to have overall Medicare margins that are higher than the average PPS hospital, and in large part this is due to the extra payments they receive through the indirect medical education and disproportionate share adjustments on inpatient payments.

For-profit hospitals had the highest overall Medicare margin at 0.1 percent in 2010, and they had positive margins for both inpatient and outpatient services.

Then turning to rural hospital margins, they were minus 2.6 percent in 2010, which was more than 2 percentage points above the urban hospital margin which was minus 4.8

percent. If we also consider the 1,300 critical access hospitals, the rural margin would be minus 1.7 percent. Critical access hospitals, if you remember, receive payments equal to their allowable costs plus a 1-percent profit margin.

The Commission is required to look at rural payment adequacy as part of our upcoming congressional report on rural hospitals. We're going to go through a few more slides here looking at what is happening with rural hospitals. The last time we took an in-depth look at rural hospitals was in 2001 when we saw that rural hospitals had much lower margins than urban hospitals and recommended a number of changes be made to improve rural hospital payments, many of which the Congress adopted. What we see now is a different picture from then and that the rural hospital margin gap has reversed. In 2010, rural hospitals' overall margins and their inpatient and outpatient margins are both higher than urban hospitals' margins.

For our upcoming report we are going to be splitting rural hospitals into three different groups based on their location, and you will see this in other presentations later today and tomorrow. The rural groups

are micropolitan, which are communities with a town of 10,000 to 50,000 and represented by the dotted line on the above chart; rural adjacent to urban areas, represented by the yellow dashed line; and rural non-adjacent, which are rural counties that do not have a town of 10,000 or more and are also not next to an urban area, and these are represented by the yellow dashed line.

What we find is that in 2010 the overall margins are higher the more rural a hospital is -- micropolitan hospitals have Medicare margins just above urban hospitals, and rural adjacent to urban having higher margins -- the next highest, followed by rural non-adjacent having much higher margins than urban hospitals. About three-quarters of the --

MR. HACKBARTH: Craig?

MR. LISK: Yes?

MR. HACKBARTH: These are just the PPS hospitals.

MR. LISK: These are just the PPS hospitals, yes. And if you think about critical access hospitals, their average margins are a little bit positive above 1, so they are going to be similar to the rural non-adjacent.

About three-quarters of the rural adjacent and

rural non-adjacent providers qualify as sole community or Medicare-dependent hospital payments which receive higher rates that are at least partially based on hospital-specific costs, and that may help explain why their performance is above the others.

While rural margins overall are above urban margins, there is often a concern about the smallest rural providers, and this has led the Congress to provide additional payments to small rural hospitals under the sole community hospital program, Medicare-dependent program, and the low-volume adjustment.

A new low-volume adjustment started, though, in 2011 and is scheduled to end in 2012. So our margins, as we have shown you, have not shown what the effect of the low-volume adjustment, this new low-volume adjustment is.

As we stated in September when we talked about this, this policy has three problems: First, hospitals do not need to be isolated from critical access hospitals to qualify for this adjustment. Second, the adjustment is not empirically based and uses just Medicare discharges rather than total discharges. Third, it duplicates the sole community and Medicare-dependent hospital programs. So what

happens to margins when we add this new low-volume adjustment to payments?

Well, what we find is that low-volume hospitals already have higher Medicare margins than other hospitals. The average inpatient margin in 2010 was minus 1.7 percent for all hospitals, but the smallest 20 percent of rural hospitals already had a higher margin of 0.8 percent, mostly due to the SCH and MDH payments. When we add the new low-volume adjustment onto these hospitals' payments, the inpatient margin rises to 14 percent, and if we even look at the next 20 percent of hospitals, the 20 to 40 percent smallest hospitals, their margin goes from 0.1 percent to 9.4 percent.

So let's turn to what we believe will happen to margins in 2012 in our projected margins, and here we take account of what policy changes have taken place in 2012 and since 2010. So here we estimate that the overall Medicare margin will fall from minus 4.5 percent in 2010 to minus 7 percent in 2012.

The drop in margin is primarily due to reductions in inpatient payment rates that occurred in fiscal year 2011 and 2012 to account for changes in hospitals' documentation

and coding. These documentation and coding adjustments largely offset the payment updates, resulting in inpatient payments increasing by only 1 percent from 2010 to 2012.

Given hospitals' strong overall financial performance in 2010, though, we expect cost growth has moved up in 2011 and 2012, reflecting a loosening of expense controls after a highly profitable 2010. Increased IT spending and higher inflation input prices also likely may contribute to a loosening of restraint on costs.

Next we show three indicators of hospitals' all-payer financial performance, total all-payer margins, the yellow line which represents performance for all hospital lines of business, the operating margin which is the green dashed line, and a measure of cash flow which is represented by the blue dotted line. We measure cash flow as earnings before interest, taxes, depreciation, and amortization, or EBITDA. The point of this slide is to show that after a historic low point in 2008 hospital profits and cash flow have increased to new highs. In the past, increases in overall hospital profitability have been followed by increases in hospitals' costs per discharge.

Jeff is not going to discuss our analysis of

financial performance among efficient hospitals.

DR. STENSLAND: So Craig just explained how the average hospital continues to have small losses on Medicare patients. But as we mentioned in your written materials, hospitals are under varying degrees of pressure to constrain their costs, and some hospitals have higher cost structures than others. This raises the question of whether there are certain hospitals that are able to perform well both on quality and cost metrics. These are what we call "relatively efficient hospitals." We want to examine the profit margins of this subset of providers.

To determine who is relatively efficient, we used the same criteria as last year. I will not go into detail, hospitals are categorized as relatively efficient if they performed well on mortality, readmissions, and standardized inpatient costs per case in three consecutive years -- 2007, 2008, and 2009.

After identifying the group that historically has been relatively efficient, we then ask how well they performed in 2010, and here are the results. We ended up with a group 188 hospitals that have historically been relatively efficient providers for three straight years.

The group of 188 hospitals represents about 9 percent of all IPPS hospitals that had usable data for all four years of our analysis.

If we look at the first column of numbers, we see that the relatively efficient hospitals had 17 percent lower mortality and 5 percent lower readmission rates, while keeping their costs 11 percent lower than the national median. Lower costs allow these hospitals to generate positive Medicare margins on their Medicare patients, with a median margin of 4 percent.

We also found that 69 percent of patients rated the relatively efficient hospitals either a 9 or a 10 on a 10-point scale. This is slightly better than the comparison group which received a top rating from 66 percent of their patients.

Now I want to shift gears a bit to discuss how we need to correct for documentation and coding changes which have historically resulted in overpayments to hospitals in recent years. As we discussed in detail in your mailing materials, after MS-DRGs were introduced in 2008, hospitals had an incentive to code in a more detailed fashion. They started to code with more detail which resulted in increased

payments without a real change in patient severity or the costs of care. So to make the transition to MS-DRGs budget neutral, we need to offset these overpayments.

CMS has authority to offset the $7 billion in overpayments that occurred in 2008 and 2009. However, overpayments are expected to continue in 2009, 2011, and 2012. CMS will not have corrected its rates to prevent further overpayments until 2013.

Therefore, CMS needs new authority from Congress to recover the over $11 billion in overpayments that have or will occur in 2010, 2011, and 2012.

In its update recommendation last year, MedPAC stated that Congress should direct the Secretary of HHS to recover all of these overpayments.

This slide reviews how the overpayments would be recovered under the Chairman's draft recommendation that I am about to read to you. Under current law, existing adjustments for productivity and documentation and coding adjustments are expected to lead to a zero update. This is the top row. This is also the starting point that Glenn talked about earlier for our deliberations. However, CMS is currently reducing rates by 2.9 percent to recover past

overpayments in 2008 and 2009, as I just discussed. Under current law, this adjustment is scheduled to expire in 2013. So when this adjustment expires, the payment rates would increase by 2.9 percent, resulting in a bump-up in rates received for inpatient services. Consistent with the Commission's past recommendation that all overpayments should be recovered, the Chairman is proposing that the increase in payment rates be reduced to 1 percent. The difference between the 2.9 percent and the 1 percent, or the 1.9 percent you see in the third row, would be left in place to recover all overpayments that occurred in 2010, 2011, and 2012, and that 1.9-percent adjustment would probably have to be left in place for at least five years to recover all those overpayments.

The one thing we do not show on this slide is also another change that will occur in 2013, and that is the readmission penalty, which is expected to reduce payments by approximately two-tenths of a percent on average.

So now I will read the Chairman's draft recommendation. The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2013 by 1 percent. The Congress should also require the

HHS Secretary, beginning in 2013, to use the difference between the increase in rates under current law, currently projected to be 2.9 percent, and our 1-percent update to gradually recover past overpayments due to documentation and coding changes. The spending implication for 2013 is that it's expected to increase payments relative -- decrease payments relative to current law. It is not expected to have any impact on beneficiaries or providers' willingness to treat patients.

Now, I just want to recap the rationale behind the update recommendation.

First, adjustments for documentation and coding are needed to recover all overpayments and restore budget neutrality, but we want these recoveries to be small enough so that they do not cause a financial shock to hospitals. Given the payment adequacy indicators, a 1-percent increase is sufficient to preserve payment adequacy for reasonably efficient hospitals. And the difference between the 2.9-percent increase and the 1-percent increase could be applied to recover all overpayments due to documentation and coding changes.

The 1-percent increase on the outpatient side is

appropriate for two reasons: First, we see strong outpatient volume growth of 4 percent, which suggests payments are adequate. Second, we are starting to see a shift in the site of services from physician offices to hospital-based physician practices. We do not want to encourage this shift by making the increase in hospital outpatient payments significantly larger than the increase in other sectors.

One particular area of concern is the growth in physician office visits in hospital-based practices, and now Dan will go through that issue in detail.

DR. ZABINSKI: At our November meeting, we discussed the issue of hospitals increasing their employment of physicians. Many factors have been cited as contributing to this trend such as a desire of new physicians to have stable, predictable working hours, increased difficulty and cost of running a private practice, hospitals positioning themselves to establish ACOs in advance of PPACA rules, and the potential for increased reimbursements from Medicare and private payers.

Regardless of the cause for this trend, it is likely to cause billing of services to shift from free-

standing physician practices to OPDs.

The result of such a shift would be to increase program spending and beneficiary cost sharing even though the care received by patients may not change at all.

As an example of how a shift of services from free-standing practices to OPDs could affect program spending and beneficiary cost sharing, consider the case of a mid-level office visit indicated by CPT code 99213. I'd like to focus your attention on the last row of numbers on the table.

If this service is provided in a free-standing physician practice, total payment for the service would be the nonfacility payment rate in the physician fee schedule of $68.97, and the physician would receive the entire payment.

But if it is provided in an OPD, there would be a reimbursement for the physician's service at the facility rate in the physician fee schedule of $49.27. Obviously, this is a lower rate than the $68.97 that is paid to the physician in the free-standing practice. But I want to emphasize that this difference is due to lower reimbursement for physicians' practice expense in the OPD, but

reimbursement for the physician work effort is the same in both settings

Then, in addition to the $49.27 paid to the physician when this service is provided in an OPD, the hospital would be reimbursed $75.13 under the outpatient PPS. If you add these two reimbursements together, you get a total payment of $124.40 if the service is provided in an OPD, which is 80 percent higher than the $68.97 paid in a free-standing practice.

This substantially higher payment in the OPD over the free-standing practice occurs for most services. And if Medicare is to be a prudent purchaser of medical care, it may be appropriate to eliminate these payment differences, as long as the service can be safely provided in both settings.

The simplest option for addressing this issue is to set the rates in the outpatient PPS and the physician fee schedule such that Medicare payments are equal whether a service is provided in a free-standing practice or an OPD. However, we are concerned that such a move would fail to account for differences between sectors in terms of patient severity, costs of standby capacity that are incurred by

hospitals, and packaging of ancillaries, which is typically higher in the outpatient PPS than in the physician fee schedule.

So because of these issues, for the present we have decided to focus payment equalization to evaluation and management outpatient office visits because the complexity of the cases is addressed for these services through the CPT system, the cost of standby capacity are generally allocated to other areas of the hospital, and the level of packaging for these services is similar in the outpatient PPS and the physician fee schedule.

On this table, we have an example of how equalizing payments across the free-standing practices and OPDs for a mid-level office visit might work.

The idea is to set the outpatient PPS payment rate equal to the difference between the nonfacility practice expense rate and the facility practice expense rate in the physician fee schedule.

If you look at the middle row of numbers on the table, this drops the outpatient PPS rate from its current level of $75.13 to $19.70.

Also, the third row of numbers on the table

indicates that this drops the total payment if the service is provided in an OPD from $124.40 to $68.97, which is the same total payment if the service is provided in a free-standing physicians' practice.

Obviously, this policy would reduce hospitals' $153 billion of Medicare revenue, but for most hospitals, the effect is relatively small, as 78 percent of hospitals would have their overall Medicare revenue reduced by less than 0.5 percent.

However, the effect on hospital revenue differs by hospital group. For example, we estimate that Medicare revenue would decline by about 1.2 percent for major teaching hospitals but by as little as 0.2 percent for for-profit hospitals.

In addition, there is wide variation of the effect on Medicare revenue, as 10 percent of hospitals would see no effect on Medicare revenue and 10 percent of hospitals would see Medicare revenue decrease by at least 1.3 percent.

Based on a goal of equalizing payments rates for office visits across free-standing practices and OPDs, the Chairman's draft recommendation is: The Congress should direct the Secretary to reduce payment rates for evaluation

and management office outpatient visits provided in hospital outpatient departments so that total payment rates for these visits are the same, whether the service is provided in an outpatient department or a physician's office.

The spending implication is that it is expected to decrease spending for 2013 and over five years because of lower payment rates in the outpatient PPS. For beneficiaries and providers, this policy may slow or stop the shift of services from free-standing practices to OPDs. It will reduce beneficiary cost sharing, and because of the lower OPD payment rates, we may need to monitor beneficiaries' access to these services.

The rationale behind this draft recommendation is a summary of points we discussed earlier:

First, hospitals are acquiring physician practices, which has resulted in services shifting from free-standing practices to OPDs. And although the clinical benefits are unclear of such a shift, Medicare payments and beneficiary cost sharing are typically much higher.

For the time being, we focus on equalizing the OPD and physician office payments for E&M outpatient office visits because differences in patient severity for these

services are addressed through the CPT coding system; hospital costs for maintaining standby capacity are generally allocated to other areas of the hospital; and there is little or no difference between sectors in terms of the packaging of ancillary services.

Now we turn things over to the Commission for discussion and questions.

MR. HACKBARTH: Okay. Thank you. As usual, we will do our two rounds of comments: the first round, clarifying questions; the second round, more expansive comments.

As always, when we do the update portion of our work, when we go to round two, I would ask each Commissioner to state their current inclination on the draft recommendation -- for it, against it; if you're against it, what might you like to see changed that might make it more appealing.

Before we turn to round one, let me just make a couple additional comments about the overall work we are embarking on with the update analysis.

By statute, according to the statute that governs MedPAC, our responsibility to the Congress is to recommend

rates consistent with the efficient delivery of services, which efficiency taking into account both the cost and quality of the service. In the presentation we just heard on hospitals, Jeff outlined our efficient provider analysis for the hospital sector. We began several years ago to introduce that type of analysis, sort of sector by sector. We have not completed that for all of the different provider groups, but you will hear that efficient provider discussion and analysis pop up several times during the day. That's because that is the statutory charge for the Commission: rates consistent with the efficient delivery of services to Medicare beneficiaries.

Then I also just had one observation specific to hospital, and that has to do with the recovery of diagnosis and coding change overpayments. I raise it here because this is an issue that has arisen not just for hospitals but for home health and Medicare Advantage plans and skilled nursing facilities. And MedPAC's approach to this across all the sectors has been that when there is an increase in payments due to a change in the diagnosis and coding structure used in that payment system, the money should be fully recovered. Changes in the case mix system should not

result in increases in payment. By definition, they should be budget neutral. And so what we are discussing here in the hospital sector about recovering the DCI overpayments is consistent with a broad policy that we have applied for years across all sectors in the Medicare program.

Our view has been and continues to be that if Congress wishes to increase payment rates, the appropriate way to do that is through payment updates, not by forgiving and not collecting past overpayments due to changes in the case mix system.

So let's begin with round one clarifying questions.

DR. CASTELLANOS: I just have two questions. I've received a lot of data and a lot of information concerning the E&M issues of the outpatient and the physician office. Is there any data to show that the patients seen in the HOPD have the highest severity of illness? I know we adjust it with coding, but is there any data that shows that?

DR. ZABINSKI: Ariel is going to handle that, I guess.

MR. WINTER: So we looked at this using the HCC risk scores, which are used to adjust Medicare Advantage

payments, and those look at the expected costliness of a patient based on their prior-year diagnoses from all of their services, and we found that beneficiaries who receive E&M services in the HOPD have higher average risk scores than beneficiaries receiving E&M services in physicians' offices.

The question is whether this means that they are more costly to provide an office visit for, and we think that because the coding structure accounts for differences in the time involved in a visit and the level of complexity of decisionmaking, that accounts for differences in the cost of individual beneficiaries. So if a beneficiary is sicker -- if because a beneficiary has more diagnoses they need more time, that will be reflected in a higher code for that visit.

DR. CASTELLANOS: Thank you. I'll comment more on that in the second round.

The second question I have is on page 16. It just surprises me that the share of the patients' rating of the hospitals really is basically the same. You know, we have public reporting now both on physicians and hospitals and nursing homes, and, you know, here we have 10 percent of the

hospitals that are relatively efficient, they have lower costs, they have lower mortality. Is that message not getting out?

You know, one of the things at least I have taken away from MedPAC is that we want the patients to go to the least-cost, most efficient provider. And, you know, I would think the satisfaction would show up in patient response.

DR. STENSLAND: Well, there are going to be a whole host of reasons why the patients rates it a 9 or a 10 on a 10-point scale and note most people are. And I don't think that just -- they're not ranking the hospital just on mortality. In fact, mortality is probably not a ranking part of it for that patient because the patients who die aren't eligible for the survey.

[Laughter.]

DR. CASTELLANOS: But their families are.

DR. STENSLAND: In terms of the readmission rates, there we do see a big correlation in that hospitals with high readmission rates do tend to have much lower rankings on the quality of patient satisfaction, and that might contribute some to the 3 percent. Standardized costs, the lower costs probably don't necessarily translate into higher

patient satisfaction because they're not paying those costs. Somebody else is paying those costs. And if the higher costs happen to be more amenities, then maybe it's prettier, and maybe there's nicer paneling in the entryway that might affect your satisfaction, but it might move you out of the efficient group. So that's maybe why we don't see this big difference, but I thought it was somewhat reassuring that at least on average the patients are more satisfied with the efficient group than the others.

MR. HACKBARTH: Yes, I think it is broadly true, and there may be others here who are way more expert than I, but there doesn't seem to be, generally speaking, a strong connection between patient assessments and patient satisfaction with data about cost, mortality, outcomes. They're assessing care based on different considerations, and perhaps in part because we have not done a very good job in terms of making these other data understandable and usable for patients in assessing their experience. So they're evaluating their interactions with the doctors and nurses and other staff and the facilities and the like more than ultimately outcomes.

DR. STUART: One of the rationales for equalizing

the rates in the fee-for-service and OPD is related to the acquisition of practices by hospitals, and my question is: Are the practices that are being acquired primarily among specialists who are billing for E&M services, or are they not? And if so, do we have some sense of the proportion of E&M services that are being provided by these acquired practices?

DR. ZABINSKI: Here's what I know: that the proportion of E&M services provided in OPDs is increasing. In 2008 it was about 6 percent; in 2010, about 8 percent. That doesn't sound like -- well, you know, proportionally, that is a pretty big increase. It's not a big movement yet, but maybe --

DR. STUART: My point is, do you see this as a mechanism that is going to lead to more E&M services being provided within the hospitals? I think you've answered yes, at least indirectly, by that measure.

MR. GEORGE MILLER: Do you have a sense that especially among the efficient hospitals that you've identified if the same phenomenon is taking place within them as well, and that is, are they acquiring physician practices at the same level as the percentage in the

chapter? Is it greater? Is it smaller?

The second part of that clarifying question would be: If so, what would the impact be of this recommendation on the efficient hospitals and their margins and operations?

DR. STENSLAND: The relatively efficient group, when we looked at this in more detail last year, was slightly more likely to be integrated through some type of common ownership of the physician practice, between whatever entity owns the hospital and owns the practice. Think of the integrated delivery system being slightly more common.

MR. GEORGE MILLER: Slightly, okay.

DR. STENSLAND: So they would probably on average have a little bit bigger effect, so you're thinking of their margin on average is 4 percent, and maybe, I think, Dan had said the reduction in payments would be something like 0.6 percent, and maybe it might be slightly more. So you could see that, all else equal, their margin going from 4 down to the lower 3's or 3.

MR. GEORGE MILLER: And the follow-up question: Would they then stay as an efficient provider with the impact of this?

DR. STENSLAND: They would, and one of the things

we do is when we look at efficient provider, it's not every we want to know, but right now we're looking at the inpatient cost per discharge, and none of this shift in Medicare payments would affect the inpatient costs per discharge. We don't think it would affect any -- have a big enough effect to affect any of the outcome measures.

MR. GEORGE MILLER: But it is going to affect cash flow, and they've got it all set that reduction in cash flow in some way, either reduce cost somewhere else or find another way to account for this loss of revenue, because there's going to be a shift in revenue.

DR. STENSLAND: Right, so if you look at them, I think I have there Medicare margin in your mailing materials, their total margin.

MR. GEORGE MILLER: Right, right.

DR. STENSLAND: So if their Medicare margin goes down even more than 0.6 that Dan talked about, even if it went down a full point, that would be a 1-percent reduction in their Medicare margin and they would be down to 3 percent. But that's only their Medicare revenue, and that would still be averaged in with all their own non-Medicare revenue, which I think is on the order of 5 percent or

something.

So, on average, you would see them moving their margin down by some fraction of 1 percent, which would still leave their total margin above, I think, the historical averages if you look over the last 20 years.

If you look in the aggregate of the hospitals' overall picture, it's not going to be that big because it's not a huge part of their Medicare revenue, and so it's even a smaller part of their total revenue.

MR. GEORGE MILLER: Total revenue.

MR. HACKBARTH: And the other thing I'd add to that is that the hospitals that are in the efficient provider group tend to be hospitals that have coped very well with constrained financial resources. In fact, part of our analysis, as you know, George, in the chapter is we look at hospitals that are under financial pressure and compare them to hospitals that are not under financial pressure, and the ones who are under financial pressure tend to have lower costs than the ones who don't face pressure. And then the efficient providers are the ones who combine that low cost also with high quality.

So, you know, broadly speaking, efficient

providers, when they are faced with revenue constraints, respond well to that constraint.

MR. GEORGE MILLER: So far, yes.

MR. HACKBARTH: So far.

MR. GEORGE MILLER: So far

DR. STENSLAND: Just maybe to add on to what Glenn said, my answer just talked just about the revenue side, and it's possible that this change in law could end up reducing the expense side, also, the reason being that people might be converting -- you know, you have a physician office building. You buy that practice, and your question is: Should I take that office building and convert it to hospital's conditions of participation in it and incur all those extra expenses? Right now the answer is maybe yes because Medicare is going to pay me more money for all these visits. And if Medicare is not going to pay you more money for those visits in the future and it's not generating anything for your patients, you might say, "I'm not going to incur those extra expenses." So we might actually see some shrinking on the expense side that would partially offset some of the decreased revenue.

MR. HACKBARTH: Clarifying questions?

MS. UCCELLO: Yes, if we can just go to Slide 18, I just want to confirm I understand this correctly. So this 2.9 percent actually incorporates a lot of things, not just the elimination of that 2.9-percent recovery, and that recovery is just for past overpayments, but there's a 1.9-percent reduction to make sure that future payments aren't overpaid, and that is still being taken out.

DR. STENSLAND: I have another slide that might explain that. I just have an extra just in case I was not completely clear, and I guess I wasn't. So here it is. This is kind of more of the full story of how this works under current law. Under current law, there's a market basket forecast of 2.9 percent, and there's a 1-percent adjustment for productivity and budgetary adjustments. Then there's also another 1.9 percent, which is in current law that CMS has to take, to prevent future overpayments. That authority is already in place. So that kind of brings them down to a zero projected update under current law. And then we add on this expiration of this 2.9-percent reduction which is currently built into the system, which is going to expire in 2013. So then that is the 2.9-percent bump-up. I hope that is clear.

DR. MARK MILLER: [off microphone].

MS. UCCELLO: No, that was exactly what I was -- so thank you, and it wasn't planned.

MR. HACKBARTH: And for the benefit of our two new Commissioners, as I said earlier, we are committed to the principle that we need to recover overpayments that are due to just the shift in the case mix system, and what we've committed to in the past is to do that gradually over a period of years. But given the pressures on hospitals, we decided last year that hospitals ought to at the bottom line get at least a 1-percent increase. And so basically what we are saying is we want hospitals to get a 1-percent increase, and then the difference between the 2.9 and the 1 percent is credited to the overpayments, paying down the overpayments due to case mix change.

Did that come out clearly? Do people understand what I'm saying there? Okay.

DR. HALL: So I'm going to direct it at Jeff and Craig, I think. Could we go back to 16? This slide really caught my attention in that this sample shows a 17-percent lower mortality, and that's huge. That is just astonishingly huge.

So these are Medicare-specific data, and the 188 hospitals, do we know anything more? Can we just a little slightly deeper dive into the characteristics of these hospitals?

DR. STENSLAND: Yeah.

DR. HALL: For example, if I were to be a cynic, I would say that these are hospitals that are very efficient at cherrypicking patients, for example. Some systems have a reputation for that. I just want to make sure how reliable the sample is for the conclusions that we're drawing from them.

DR. STENSLAND: There's probably more detail on this in our chapter last year. We went into more detail about who these are, but let me try to address some of those concerns.

One concern is these are places that are cherrypicking kind of the healthy or the wealthy folks, and they're not serving the poor. So what we did is we eliminated anybody that was in the bottom 10 percent in terms of their Medicaid load --

DR. HALL: Right, I understood that.

DR. STENSLAND: -- to get rid of those folks.

There's another concern that maybe in some areas of the country they just admit a lot of people, and if you're admitting a lot of people that maybe don't need to be there, you have good outcomes. So what we also did is eliminated the 10 percent of the places that have the highest spending out there to try to eliminate some places; you know, there are certain places like in Florida where there's lots of spending that would not be eligible to be on our efficient provider list, not because we're sure they're not, but just because we're concerned that maybe they aren't, because maybe they're just admitting a lot of people that don't really need to be there and that's why they look good on outcomes.

In terms of who these places are, there is a spectrum across the whole stretch of the country. There are some mid-sized rural providers, and there are lots of larger providers. But, on average, they tend to be a little bit bigger, and the reason for that is it kind of goes back to some of the discussion we had on rural quality a little while ago where the larger ones do tend to have lower mortality, and you do for that reason tend to have a little bit -- larger hospitals tend to be in the relatively

efficient group. But we do have some hospitals that serve a broad range of patients. I think in the past the efficient hospitals that we've mentioned here as examples just because they came to talk to the Commission in the past are places like Virginia Mason, who's done a lot of re-engineering and I think has helped them get there. There's also places that somehow are able to do quite well despite a diverse patient mix, like Denver Health, which has a lot of Medicaid patients and still tends to do very well on their outcomes. So that just gives you a little favor of who might end up there.

DR. HALL: Thank you

MR. HACKBARTH: Jeff, remind me, there are teaching hospitals in the efficient provider group, and it is roughly in proportion to their overall representation among Medicare hospitals? Or is it --

DR. STENSLAND: I would have to check. It's roughly in proportion. It might be slightly higher. And I don't think it's necessarily their teaching mission but that they tend to have higher volumes, which tends to help your mortality.

MR. HACKBARTH: But just in terms of giving Bill a

flavor of the group.

MR. KUHN: Two quick points. One, I don't want to speak to this slide, but thanks for the slide on page 24 on the impacts. I know that's something that we talked about at the last meeting, so I appreciate you all producing that.

What I really wanted to ask about is a question on page 9 on the margins, and in round two I'll talk a little bit more about margins and variability of margins, because twice in the chapter we talk about policy issues that are driving that variability. There's also some non-policy issues that drive that variability, and like I said, I'll speak more about that.

But I'm curious about any kind of speculation or additional information you can share about the documentation and coding adjustment and how that might -- as we continue to move forward for the recovery on that, and how that might impact margins, particularly on those hospitals that probably don't have the kind of patients that could recover more in terms of the documentation and coding. I'm thinking more rural hospitals that might have fewer patients, that might have the set of codes where the greatest opportunity for coding might be, maybe LTCHs, which tend to specialize

more -- many of them specialize more with vent patients or wound care patients.

So can you talk about, as we move forward, continue to move forward and talk about the documentation and coding and to deal with that case mix increase, will there be variability across different types of hospitals as a result of that as we go forward and margins for different types of hospitals?

DR. STENSLAND: So we did look at that and CMS looked at that, and both us and CMS found that the increase in your reported case mix was broad across the board, and this is for rural hospitals, even for sole community hospitals. They all showed, when you ran those claims through the two different groupers, that they got a big bump-up in their case mix under the new grouper. And I think part of that is that a lot of the stuff that's giving you the bump-up is not necessarily something that's necessarily really sophisticated. I think the example we used before is under the old system you used to get credit for saying "heart failure." And as the coding people say, if the doctor just put "HF" on the documentation, they would get a credit for that in terms of a comorbidity. Now all

they have to do is put in -- describe what it is. Is it diastolic heart failure? Is it systolic heart failure? And the clinicians tell us that basically you can almost always tell what kind of heart failure it is. And so it's stuff like that, you know, of a heart failure issue, that's going to be kind of spread all across the board, and that may explain why we see the same kind of level of bump-up in the rural hospitals as we do in the urbans and the sole communities, as we do in the teachings. There's just not that much difference in how much they're benefitting from the more detailed coding.

DR. BERENSON: I want to ask a few questions to try to reconcile some differences of views between the AHA letter we received, which was very helpful, and some of the outpatient E&M issues -- I guess this is mostly for Dan -- in your presentation, if I could.

You emphasized that costs were for standby capacity, a whole list of regulatory obligations are spread pretty much into the services where those particular items apply, not necessarily E&M. AHA emphasizes their ability to spread across all services. So I have two questions.

How does that actually work? Are they spreading

those services sort of equally? Or are they targeting?

And then what I'm even more interested in is: What happens if we do equalize the payments? Will the hospitals be able to spread those costs to all the other services? And would that ultimately result in an increase in payments for those other services if we go down this road?

DR. ZABINSKI: Okay. My understanding is on the cost reports, you know, there's specific cost centers. For this particular issue, think about the clinic cost center and the ER cost center. My understanding is that, you know, the direct costs, things like the wages and the equipment used in the particular centers, they apply directly to the center, and there's no real spreading across the different centers. Then you have your indirect costs -- executive compensation, accounting costs, and that sort of things -- and those are apparently spread evenly across all the centers, not just the ER and the clinic but all of the cost centers. And when it comes to the standby capacity, the direct costs are much higher than the indirect costs, so it's like the bulk of the standby capacity costs are being directed to the ER cost center but, you know, not all of

them. That's my understanding.

DR. BERENSON: Okay. So how about the second part? If we actually do limit their ability to spread costs into E&M, do we ultimately pay for it somehow in higher rates for other services the way that's calculated?

DR. ZABINSKI: I don't think so. You know, knowing how the rates are set in the outpatient PPS, you know, whatever -- they adjust charges, they take the charges from the claims and use the cost center specific cost to charge ratios to adjust then the costs. And so to the extent that the costs are directed to the centers, they're going to be reflected in the costs that are used to obtain the payment rates, so I don't see it.

DR. MARK MILLER: So if I could just join in this for a second. We talked about this a little bit, and this is what I took away from the conversation when we talked about it a bit. We also got the letter. It was delivered to our homes.

This is the way I took it away. If you just had a purely mathematical example, somebody could say, "I'm going to move costs to other parts of the other services and potentially try and get out from under the policy," which is

his underlying question. But there's a couple of things that I took away from our conversation.

Number one, if you could do it, the effect is going to be relatively small because, remember, we're talking about on average a half a percent of, you know, the reduction and then allocate it through your Medicare portion of your business, which is also a portion of your business. But the second thing is it requires changes in the Charge Master, so you would have to be out there taking your charges down, and the drag on that move is that basically what you're negotiating with private payers you would also be bringing down your reimbursements.

So I took away, when we talked about this, in a purely mathematical sense, yes, you could try and do this, but the effect is small, and you would have implications for a larger line of business out there that would create some drag for you to --

DR. BERENSON: Because of that reliance on the Charge Master for determining those rates.

The second question has to do with -- oh, go ahead.

MR. HACKBARTH: Before you go on to that, Peter

had --

MR. BUTLER: I'll just be very brief. There's a difference between simply the accounting of this and how to allocate it and what are the real differences in costs of these things if they're free-standing versus not. And so another way to look at it, though, is there are some additional costs. You're Joint Commission accredited, you have to go through that process, and that's an incremental cost, and every clinic has to be a part of it. It has nothing necessarily to do with the accounting of how this is done. So it's up by a little bit, just the cost accounting of it. What we really should be understanding, what do you have to do and what value is it in a real cost kind of way? That's the issue. And there are a little bit more costs, and you're also likely to kind of have electronic records and do a number of coordinated care better. But that's really not the costs that we're talking about here, just from a regulatory standpoint what are you now subjected to that are real additional costs.

DR. MARK MILLER: And I think that exchange also occurred a bit over here, which is, okay, if you incur those costs -- I think Jeff was saying this. So in the end

Medicare or private payers pay those costs if the hospital chooses to do it, and I think the fundamental question is: What's the gain to the system of incurring those costs if the service can be provided in a setting that doesn't incur those costs? And that's kind of the fundamental question in play, I think.

DR. BERENSON: My second question has to do with the packaging issue. On E&M, my understanding is that there's not a lot of packaging. Could you go over that?

DR. ZABINSKI: Okay. There's 10 CPT codes for these E&M visits, and I looked at a thousand claims for each one, so 10,000 claims. I found that on the average claim the cost of packaging is about 2.5 percent of the total cost. Most claims for these things don't have -- had no packaging, like 95 percent has zero. The items that typically are packaged were things like testing blood oxygen level and then packaged drugs, drugs that aren't paid separately under the outpatient PPS. So, yes, the level of packaging is pretty low.

DR. BERENSON: So what I might have imagined, like packaging a urinalysis and other sort of things like, are not packaged in the outpatient PPS.

DR. ZABINSKI: Right.

DR. BERENSON: Okay. The third and last, because I know I'm going over, your guys' emphasis, with Ariel helping, that the CPT coding system sort of self-corrects permits you to capture case mix to some extent, and I'll have some comments in round two about that. And it is pretty comparable for the hospital and the physician. Their letter emphasizes that they have some separate instructions about how they're supposed to code that makes them non-comparable. Could you comment on that?

DR. ZABINSKI: Yes. My understanding is that these codes don't -- you know, that the hospitals have some leeway in how they do this, but they are instructed to follow the intent of the CPT coding descriptions. I guess that's my bottom line on it. They're supposed to follow the intent of it as, you know, physicians do when they're billing in their offices.

DR. BERENSON: Do we have data on what the distribution of office visits are for outpatient departments versus under the physician --

DR. ZABINSKI: You meant by the CPT codes?

DR. BERENSON: Yes. Common office visits.

DR. ZABINSKI: It was a little on the surprising side. It's not terribly different, but, you know, they go from high to low. There's five for new patients, five for established patients, and they go in order from, you know, highest to lowest in terms of severity. And there's a little bit more higher codes coded in the free-standing practice than in the outpatient departments, which kind of surprised me a little bit. I thought it would be the other way around.

DR. BERENSON: Okay. Thank you very much.

DR. NAYLOR: On Slide 24, I was just trying to understand a little bit more about the differences in percent reduction of Medicare revenue for major teaching versus non-teaching or other teaching facilities. I know about IME and disproportionate share adjustments that are made that are not affected by this, so why would you expect to see these differences?

DR. ZABINSKI: As far as the percentages we have here? I would guess that -- Craig actually has done some stuff on this, but, you know, the teaching hospitals, or the major teaching hospitals, they often have these clinics. They're located in, I think, you know, the inner city and

they serve often has physician offices. I think Craig could probably expand on that a little bit.

MR. LISK: I mean, for the major teaching, you have the resident -- it's a resident clinic which it operates -- the physician office operates as an outpatient clinic in the hospital, often, so that's one factor. So they may be different services that operate as an outpatient clinic in the hospital rather than E&M so -- rather than an external office. Or even in some cases if they meet the qualifications -- if it's off-site and they meet the qualifications for -- we had talked about an off-site clinic might also be counted as a hospital outpatient, but it's part of how they structure their teaching program and things like that. But, again, in outpatient, we don't have the teaching adjustments on the inpatient side, too, remember.

MR. BUTLER: So page 13, a quick question on IT. You made reference that IT may be one of the reasons for deterioration in margin, and yet that statement suggests that the incentive, the HIT payments might be larger than the cost increases. That's what led you to believe -- which I don't think is the case, but -- and it also contradicts the statement that you said that this could be a contributor

to a decline in profitability. So I'm not sure what you meant.

DR. STENSLAND: So what we meant is we have data in 2010, and we're trying to project data for 2012. And so the two things we project is the change in the payments and then the change in the costs. And we see IT affects on both sides.

In terms of the payments, we see a pretty big increase in payments because there's going to be a lot of people either getting -- a lot of people getting their first-year IT payments and a lot of people getting their second-year IT payments in 2012. That's on the payment side.

We do think probably incrementally that might be a little bigger than the incremental difference between their 2010 costs and their 2011 and 2012 costs. And part of this is we think there's already some IT cost built in up in 2010 data, but they may have some incrementally higher costs in 2011 and 2012, and that's part of the reason that we thought that cost growth was going to increase from around where it was at around 2 percent moving closer to 3 percent in 2011 and 2012. And part of the reason for the higher cost growth

would be the IT costs.

Does that make sense? We have a higher cost and higher revenue both happening in IT.

MR. BUTLER: Partly. Partly. I think most of us who have implemented it said the costs far exceed what the payment is for -- the incentive payment, and I think you're saying if you just carve out IT, maybe not. Maybe it more than pays for itself, which I'm not sure is the right conclusion.

MR. HACKBARTH: What I heard Jeff saying was that some of the costs are already in.

DR. STENSLAND: Right.

MR. HACKBARTH: And so they've served to depress the reported margins. So they're already baked in the cake, and now you have payments coming in that will tend to elevate the margins.

MR. BUTLER: I hear that point. There are also ongoing costs of having these things in. It is not just like a one-time capital cost.

MR. HACKBARTH: Yes.

MR. BUTLER: It's interesting. I think there are only about 300 hospitals so far that have gotten any

payments. Somewhere around that is the last number I saw. Is that about right?

DR. STENSLAND: I think that's about right, but I don't think we have the end number yet for the first year. I think there's going to be -- what we hear, at least, is there's a lot of hospitals coming in at the very end of the first year to get the money, and like I think even if you look at some of the public hospital chains, they talk about how much money they're expecting to get, and they see a lot of big influx in their revenue, either at the very end of 2011 or at the start of 2012, kind of in terms of the timing of it.

MR. BUTLER: Okay. Let me jump forward to 24, which I do appreciate, too. You're beginning to look at where this issue falls in terms of its impact, although I would say that you need a deeper dive. But I first wanted to clear up any inconsistencies, because in the written material you have different numbers for some of these categories than you do here.

For example, you say that the urban impact or percentage of revenue is 0.8 and the rural is 1.0, and you also say that the major teaching hospitals are 1.6, and here

they're 1.21. What's the difference between those numbers?

DR. ZABINSKI: In the text, that is the percent of the revenue. This is the effect that the policy would have on the revenue. So, in other words, for the 1.0 we saw for rural, that's the percentage of their total revenue that is these E&M visits. The 0.75 is the percent by which this policy that we have recommended would reduce their revenue.

MR. BUTLER: I'm not sure it's quite clear in the chapter the way it's written on that, if that's it. And I'm still not positive these are the right numbers. But go ahead, Jeff.

DR. STENSLAND: I think we can clarify it in the text, but I would think the text is -- that's the impact on your revenue lines. Here this is really the impact on your earnings line.

DR. ZABINSKI: Let's put --

MR. BUTLER: Well, we're not changing our costs.

DR. ZABINSKI: I'll try one more time.

MR. BUTLER: The costs stay the same. So if it's the revenue impact, it is the bottom-line impact.

DR. ZABINSKI: Suppose the hospital gets 1 percent of their revenue from these E&M visits, okay? Sort of on

average, the drop in the payment rate that we have under this recommendation for these things averages about 75 percent, okay? So the drop in the revenue for that hospital would be 0.75 from the policy.

MR. BUTLER: Okay. We won't get into -- these are important to clarify for sure because -- let me say it another way then. The 0.6 percent at the top is on all revenue. So, in effect, you could look at -- I'm averaging. You could look at the 1-percent update, and you'd say really it's 0.4.

DR. ZABINSKI: Fair, yes.

MR. BUTLER: That would be one way to look at this, except it is, of course, read very differently depending on whether you have these or not.

DR. ZABINSKI: Correct.

MR. BUTLER: But that would be the right way to interpret these numbers. Okay. I'll come back on my other questions or comments in round two.

DR. DEAN: If a hospital buys a physician practice in a building that's, say, in the same grounds but separate and doesn't do anything else, they just simply buy and take over that practice where it sits, they would be billing

according to these new rates, right? Is there anything else they have to do to justify or to take -- I mean, like Peter said, I understand there would be costs like, you know, extending Joint Commission accreditation or those kind of things. But are there any other significant changes that they would have to make?

DR. ZABINSKI: Ariel, do you want to -- he's the expert on this, the resident expert on it. I'll hand it off to him.

MR. WINTER: I'm not taking Mark's place. I'm just temporarily up here.

MR. HACKBARTH: We'll try it out and we'll see how it works.

[Laughter.]

MR. WINTER: So, Tom, in your example this would be an entity that's one the same campus as the hospital, correct?

DR. DEAN: Yes.

MR. WINTER: Okay. So they have to meet the conditions of participation, which generally includes joint accreditation. In addition to that, they have to operate under the same license as the parent hospital. They have to

be clinically integrated with the parent hospital. For example, the professional staff of this entity has to have admitting privileges at the hospital. The entity has to be financially integrated with the parent hospital, so shared income and expenses. There has to be public awareness, so the public has to be aware that when they walk into this entity or practice, they're actually being part of the hospital, that this is part of the hospital.

And if it's an outpatient department, which I think is your example, they would have to meet the general obligations of outpatient departments, like complying with EMTALA and nondiscrimination provisions.

So those are the general conditions that they would have to meet if they're on campus. There are some additional ones if they're off campus.

DR. DEAN: I guess I was just trying to get some sort of general sense of what the new costs would be that might be justified by this kind of a transition.

MR. HACKBARTH: And I think the way I understood your question, Tom, you were particularly focused on the off-campus. So if a hospital buys a physician practice, what are the changes that need to occur in that practice for

them to call it --

DR. DEAN: Yes, what are the new costs that might really be legitimate new costs?

MR. GEORGE MILLER: You have to bring up the facility to life safety code standards.

MR. WINTER: Right.

MR. GEORGE MILLER: That could be huge if that building didn't meet life safety codes. We did this. 2R rating doors, the ceiling deck has to go all the way to the roof, you can't have holes in the roof -- all the life safety codes -- latching doors. That could be extraordinarily expensive, especially in an old facility.

DR. DEAN: I see. Okay.

MR. WINTER: And other examples could be the medical records for this facility have to be integrated with the medical records of the main hospital, and if this facility is off campus, then they have to have integrated administrative functions, like billing and accounting and things like that.

DR. DEAN: Okay. One other question, Slide 11. Do you have a sense -- we look frequently at averages, but within averages there's oftentimes large variations. It

would be helpful if we, I think, knew how much variation there is within each one of those groups, because there clearly is going to be a difference. At least to me it would be helpful if we're talking about a pretty narrow range, are we talking about a wide range of variation?

MR. LISK: I mean, on margins in general, there's a fairly wide range of variation on the Medicare margin. If you talk about total all-payer margins, there's a little bit less variation, for instance. So, I mean, it's kind of important when you think about the Medicare margin, the hospital is actually working to go also to their bottom lines. When we talk about -- some of the hospitals that have lower Medicare margins actually -- when you think about actually the micropolitan hospitals, for instance, here, they actually have the highest total all-payer margin in the group. So in some sense, their lower performance may be because they're not as efficient because they're not under as much pressure because of the type of markets they're in. So that's another factor you might want to be considering, too, but there is variation, and we can get back to you and provide you more on that.

DR. DEAN: It does make a difference in terms of

overall policy if we've got, you know, one segment that doesn't show up in the averages but, in fact, you know, are in serious trouble financially or something. But they may get washed out because it's a relatively small number.

DR. STENSLAND: We can add that in for you, but in general, you'll probably see a little less variation in the rural than the urban, because if you had really low negative margins and you were a small, small rural, you became a critical access hospital and you just got out of the game. Most of the rest of them are SCHs or MDHs, and they're being paid on their historical costs anyway. So if they have some really high costs historically for some reason, they're getting those costs. So you'll probably see a little less variation in the rural.

DR. DEAN: But even within the critical access group, there's something like 30, 40 percent of those that have negative margins, even with their cost-based reimbursement.

DR. STENSLAND: That would be your total margin for all payer. This is on the Medicare side, this graphic.

DR. DEAN: [off microphone] I understand.

MS. BEHROOZI: I guess one of my questions was in

many of the other sectors we see spreads of margins, you know, upper quintile or quartile, or whatever, and bottom. And it seems somewhat conspicuously lacking here because we're focusing on specific types of groups and issues that we want to focus on, like the high -- the degree of financial pressure that the hospitals are under. So it might be useful to see that in the future, I realize not for today.

With respect to the efficient hospitals, though, that 188 looks like a familiar number. Is that the same group that you were examining last year, or has there been a shift? Are you look at a different time period?

DR. STENSLAND: There's a shift of a time period, so if your performance improved, maybe you get in the company; if your performance went down, you went out. And remember that we require good performance in three straight years, so one bad year for whatever reason -- you had a huge pension cost you had to fund -- okay, you're out. You somehow had a really unlucky year and you had a lot of mortality, you're out.

So there is a little bit of movement, but in general, it's a similar group and a similar size group as

last year.

MS. BEHROOZI: I was just wondering if the overall pressure brought on by the downturn in the economy, which is kind of right in the middle of the years that you're looking at now, 2007 to 2009, if the theory is that greater economic pressure should lead to lower costs, then that's one of the criteria for being in the group, if you saw that moving anybody in, if you felt like there was evidence of that happening.

DR. STENSLAND: So the difficulties in the economy tended to contract cost growth for everybody across the board, and because what we're looking at is kind of relative to all your peers, it didn't really shift who go in or out, but one thing it did do is if you look at the relatively efficient hospitals, they tend to have higher margins now than they did last year or two years ago when it was closer to zero. And there's a couple reasons for that. One is that the contraction in the economy tended to keep down cost growth. That brought everybody up, including the efficient up. And the other one is the documentation and coding improvement which kind of helped everybody and brought them up. And that's why we see the relatively efficient

providers closer to four than closer to zero where they were a couple years ago.

DR. CHERNEW: Yes, I have a question loosely about Slide 14, which is the one on total margin, operating margin, and earnings before income and other things. I have two questions.

The first one is we almost always talk about margins, and I assume you're meaning total margins, and for all those other slides, it's all the total margin number. This slide makes it look like all these different various indicators kind of move together. Is that true for all the distributions of things as well? So if I were to look -- when we look at, say, margins by rural and urban and teaching and not and stuff, is the choice of financial metric just going to be a shifter, if you will?

MR. LISK: Yes.

DR. CHERNEW: And my second question is even within the operating margin there's sort of variable and fixed costs. Is there any sense you have that the variation in how well hospitals are doing, the winners and the losers by some of our things, is due to differences in essentially the variable cost component or the fixed cost component?

And if you don't know -- and I haven't ever seen that analysis -- given the information in the cost reports, is that loosely possible to do?

DR. STENSLAND: We can do it. I think it's probably mostly in the variable cost, but we can look into it for sure.

MR. ARMSTRONG: Briefly, I was impressed to see overall margins by type of hospital, that the major teaching hospitals saw the best margin performance. And so the best I could tell, the explanation for that was the indirect medical education payments and disproportionate share adjustments. Is that really what explains that difference?

MR. LISK: Yes. It's because they get those payments, and because we said before that those payments are higher than empirically justified, that contributes to why they have higher margins.

MR. ARMSTRONG: Okay, great. So that was the conclusion we drew in our June report on IME?

MR. LISK: Yes.

MR. ARMSTRONG: Okay, great. My second question is take the example of the independent practice off campus that Tom was describing, acquired by a hospital system, and

they comply with Ariel's criteria for being able to bill under this hospital-based structure. Do they have the choice to continue to bill under the old structure and not incur the costs of compliance?

DR. STENSLAND: Yes.

MR. ARMSTRONG: Does that ever happen?

DR. STENSLAND: Yes.

MR. ARMSTRONG: And why would they do that?

DR. STENSLAND: Peter might have other answers. What we've heard from some people when they talk to us is one of the things that happens when you become a hospital-based facility is you end up sending out two bills to your patients, and so they get a bill for the physician and a bill for the facility fee, and their co-insurance goes up quite a bit. And they may not like the idea of getting two bills and having to pay more, and there may be some competitive effects to it.

There's also the extra costs, and I'm a little uncomfortable sometimes when people call these reasonable costs because sometimes these costs aren't doing anything for the patient, I think is an important part of it, and so they may want to avoid the costs. Maybe there are some

other reasons.

If you look on some of the websites of the systems, you know, some people have actually been sued for not making it clear to the patient that, oh, I'm going to a hospital-based facility and you're going to send me two bills, and when I saw Dr. X at this building I got one bill, and then I started seeing Dr. X at building number two, I got two bills for the same service. And now, you know, they try to make that clear to their patients, and you can see where it might be some sort of a competitive disadvantage if they really are in a market where there is another group that's really competing for those patients who could give them a service, a Medicare patient, that same service at a lower co-insurance.

MR. ARMSTRONG: Yes.

MR. HACKBARTH: Jeff, if a hospital-acquired practice continues to bill under the physician fee schedule, we don't necessarily know in the claims that they are now owned by a hospital. So it wouldn't be possible with the claims data to say X percentage of the acquired practices bill under the fee schedule versus the OPD system, right?

DR. ZABINSKI: That's right, yes.

MR. ARMSTRONG: Would the recommendations that we're considering deal with this confusion about double billing and so forth?

DR. STENSLAND: Nothing specifically in there that would deal with that confusion.

MR. ARMSTRONG: It would change what the dollar amount is, but the process would still be consistent.

DR. STENSLAND: Yes, the only reason that would change would be if a hospital said, okay, if I'm not getting this extra money, I'm not going to bother to incur the extra costs to make this a hospital-based unit, and I'm just going to bill like I used to. And so there may be some effect, as we said in the implications on the patient, that if they decide not to do this anymore, then the patient may be less likely to get these two bills and have the extra co-insurance.

MR. BUTLER: Glenn, one quick clarification?

MR. HACKBARTH: Sure

MR. BUTLER: Because I think I made a misstatement. On 24 -- and you agreed with my misstatement, so I wanted to -- because it's relevant to round two. 0.6 I said is, in effect, a 0.4 increase in the update because if

you take 0.6 out of the revenue and we're voting -- not today -- it's really 0.4. Actually this is based on overall revenue, not just outpatient. The outpatient update would, in effect be negative because this 0.6 is really more like a 1.5- or 2-percent reduction in outpatient revenue, while the inpatient would go up 1 percent. Right?

DR. ZABINSKI: Yeah, I thought you were referring to like the overall hospital margin, but -- okay.

MR. BUTLER: It's important because the outpatient loses 10 percent -- has a negative 10-percent margin now. It would go to something like 12 percent negative margin, all things equal. I'm just saying -- okay.

MR. HACKBARTH: Let me offer an initial round two comment. Much of the discussion about equalizing the payment rates for E&M services between physician practices and OPDs has focused on the current trend towards hospitals acquiring those practices, and maybe that's something that we don't want to encourage. I think the most basic rationale, however, for equalizing the payment rates is that we should pay at the level of efficient providers for a given service and not base our payment rates -- when we have alternative provider types providing the same service to

Medicare beneficiaries, and not base our payment rates on organizational type and structures, and trying to do that here is really -- you know, this is a first step down what I think is a longer-term path that would apply not just in hospitals but more broadly across the Medicare program. We should pay at the level of -- when there are multiple providers of the same service, we should strive to pay at the level of the efficient provider.

This is an issue that has come up in the area of post-acute care where we have different provider types caring for the same types of patients with dramatically different payment rates, and for years now we've talked about how that doesn't make any sense and we'd like to go to a payment structure that is more based on the needs of the patient, the type of the patient. We are inhibited in moving in that direction by a lack of common patient classification systems and the like. But that has long been part of our agenda to try to move forward in that area where we have overlapping providers providing the same service.

So that's the fundamental reason -- an effect of this may well be to discourage hospital acquisition of physician practices, but that's not the primary purpose.

Let's do round two, and then you can chime in at that point, George. Round two comments?

DR. BORMAN: First, I want to say that I generally support both recommendations. I'm going to mostly confine my comments to the second one because it's the one where I think perhaps I have some experience that at least makes me reasonably comfortable with agreeing with the second recommendation.

Least so in my current life but significantly so in several former lives, I've delivered patient care in these facilities, and they've been sort of the more classic, as Peter alluded to, hospital-based clinics one of whose primary missions is, in fact, to support graduate medical education, and certainly we all want to have physicians who care for us and our families to have had those experiences as part of their graduate medical education, and that's a good thing.

I think what's very different now is that the growth here appears to be driven by an economic model shift, if you will, in the practices that come underneath this, and this is not so much a more expanding what serves as an educational mission, enhances the safety net function

related to the populations. It really relates to an economic shift of the kinds of practices that we're supporting through this activity.

I can think of lots of piece on both sides of the equation about why it might cost more and why it might cost less. I will say in terms of having to have more things to care for patients, almost all the ones that I've worked in, if a patient had an acute emergency, the procedure and the protocol was to call 911. And even though the patient was being transported from building to building or a very short distance, it was not something that was an incurred cost for the clinic in order to do that. So at least personally in my experience that piece is not particularly -- you know, being able to ramp up to meet some extra need has not been the case.

I could also envision that -- I know personally that many people in certainly my career stage and perhaps a five- to ten-year window on either side have allowed -- have been positive about becoming hospital-acquired practices for a couple of reasons: number one, reduce the hassle of contracting and billing and taking on some of these rather expanded activities like electronic medical record and so

forth. Is that a reason that we should subsidize that through the Medicare program? I'm not exactly sure that that necessarily follows that mission.

The second piece is that many physicians will find that their professional liability costs go down significantly, and so they're actually -- if you think about the dollars being paid out to a Physician Plus Facility, the total volume, at least with the reduction in professional liability, should actually go down somewhat so there may, in fact, be some savings of the two together that weren't apparent in the two together unowned, if you will.

So like I say, I can argue things that are both sides of that. At the end of the day, you know, best guess for me is it's pretty close to a wash. I think if we consider that this potentially is hospitals wanting to support their ability to morph to ACOs or other integrated delivery, then in some ways we would want to support that. But we certainly have a lot of areas through the Innovation Center, the various bonuses and pilots and so forth that presumably are accomplishing that function. So I'm not sure this -- unless we make a conscious decision this is where we want that to reside -- that's an appropriate reason to argue

for this.

The fact that new graduates of residencies oftentimes want just sort of the security and the ability to focus on their practice, irrespective of some of the business pieces, again, I'm not sure is a rationale for paying more overall for the service. And at the end of the day, trying to step back to some very high level and say, okay, compared to what we're paying right now to deliver these services to patients, this is clearly going to cost us more to deliver what appear to be the same clinical services to that same patient population. I think if we could show that there was a significant quality difference, a different range in services or whatever, then this would be a lot easier to rationalize as an enhanced payment. But at the end of the day, this is a trend, a trend that's clearly increasing. It's increasing actually rather rapidly -- not an exponential or logarithmic, but certainly in a substantial upward trajectory. It's going to cost the program more. It's unclear the additional value that it's buying for the program. And so I think that probably that means that it's time to do something about.

If we say, well, it is, you know, particularly an

effect on major teaching hospitals, which, of course, are very near and dear to my heart, and we want to say, well, there is some reason for a rationalization of, you know, a one- to two-year transition, perhaps there is some merit to that line of thinking. But in the big scheme of life overall, it's a little bit hard to understand what the added value to the program of this additional expenditure is.

MR. GRADISON: I have been flirting with the idea that this should be analyzed on a marginal cost basis; that is to say, look at the new cohort of physicians that are being hired and ask the question not just about costs -- and there are some costs, although they haven't been quantified as part of the background work, there are some costs of moving from the one system to the other. But what about the patients? It seems to me that the patients that would be served by the physicians that are in the groups that are being acquired are probably the same patients. If they're not, the hospital probably wouldn't hire the doctor if they didn't think they'd bring the patients with them.

So I can't see that the severity aspect, at least in the short run, would be changed much at all, which would lead me on a marginal basis to suggest at the very least if

we maintain two different payment levels -- and I'm not advocating that, but if we were to maintain two different payment levels for E&M, in hospital, outside of the hospital, then the newly hired physicians' rate -- the reimbursement for the service for the newly hired physician ought to be phased in perhaps over a five-year period or something, not all of a sudden there's a cliff and you go from one rate to a significant higher rate.

The second thing with regard to patients -- and it has been mentioned, but the co-payment is almost doubled. I appreciate with Medigap and all, people will probably not notice that. But that's a significant hit. It's almost double in dollars and cents. That's a marginal way of -- as I say, I flirted with that idea. But then I came around to the question from a public policy point of view: Is it in the interest of the Medicare program to provide a financial incentive to a hospital to bring on these folks in significantly larger numbers prior to the hospital trying to figure out if it wants to become part of an ACO. You mentioned that, Karen, and I don't think it was mentioned earlier. If it was, I missed it. But I've been thinking a lot about ACOs -- many of us have -- and somehow the notion

of getting the cost of the program up prior to initiating a major -- let's call it what it is -- experiment, the ACOs, to try to bring the costs down, it seems to me there's some disconnect there. And I don't think I need in this group to elaborate upon that.

So I guess I'm where you are. I would support both recommendations, but I did want to explain why. Thank you.

DR. CASTELLANOS: I support both recommendations. I'd like to talk a little bit about hospitals and doctors acquiring. Dan, you gave some good answers of why they do it, why a physician does it, quality of life, et cetera, et cetera. But I think Karen really hit the bottom line. It's really an economic shift, and I think we have to be honest about that. We saw it last year with the cardiologists. Because of a change in reimbursement out of the office, they come to the hospital.

You know, it concerns me a little bit because in my community at least, I see -- it used to be five years ago, ten years ago, the doctors would be going to the hospital -- the hospitals would be going to the doctors looking, hey, we need you, we need to fix this panel, we

need to fix coverage, et cetera. Now it's the opposite way. The doctors want to go to the hospital. It's for economic reasons predominantly.

I think I'm going -- I'm a little outspoken, and I'll be very outspoken. I think there are some reasons -- I think there's probably some justification for perhaps increased costs, but certainly not 80 percent higher. Let's be real. Come on. If you can give me a good reason why they should get paid 80 percent more, I'll listen to it. But I haven't heard that. So I have a real problem accepting the 80 percent.

You know, one of the things Glenn has always said, you just don't throw money at people. You do it in a structured way and try to focus what you're doing. I'm against doing anything but what these recommendations say.

DR. STUART: I support the two recommendations and also share the general concern here that we do not have a full understanding of this dynamic of acquisition of physician practices. So I'd like to add some language into this that says, okay, next year -- or maybe not in this recommendation, but at least next year that we try really hard to increase the level of knowledge that we have in this

area.

And going back to Slide 24, just two observations on this. One is that if we thought that this was a profit play by the hospitals -- and I recognize that in order to have this happen, you have to have both sides of the market work. So this is not inconsistent with physicians having incentives to join these hospital practices. But if it were just a profit play, one might expect that the biggest hit, if you were to equalize the payments, would be on the for-profit hospitals, and that's not what we see here. I mean, they're substantially lower than the not-for-profit hospitals.

And then one thing that is a little odd with this slide is that for that comparison you've taken out the not-for-profits -- I mean the government facilities. But I'm assuming that the government facilities are in the other comparisons. At least that's what the slide would imply by the footnote. And assuming that they are, and I do the math, then the facility group that's going to be hit the hardest here on the ownership side are going to be government facilities. I think we ought to think a little tiny bit about that.

And then, finally, to pick up on Glenn's point, it would be interesting to see what the hit is -- and maybe you've already done this -- for those 188 hospitals that we consider to be efficient providers, because if they're efficient -- I mean, most of the metrics, I think, are inpatient metrics, but it would also be interesting to see what this policy effect would be on that segment.

MR. GEORGE MILLER: Yes, thank you. I believe that I'll reserve judgment on the two recommendations until I hear all of my colleagues, but the theory is sound, and I certainly understand the theory. But to your comment earlier, Glenn, when you said that Medicare should only pay for services equally across sectors, while I philosophically agree with that statement, I'll go back to my argument about especially hospitals that choose -- and I'll use the term "cherrypick" -- services that are profitable and don't, because you don't see congestive heart failure hospitals. And specialty hospitals choose only profitable hospitals, and if we would pay them the same as the hospitals, those specialty hospitals don't have emergency departments, they're not open 24 hours a day. So there has to be -- not for this recommendation, but philosophically there has to be

a differential because of a hospital that provides all complete services to the community would be different than one that chooses only select profitable DRGs performed in that hospital versus a full-service hospital that provides everything, takes care of charity care, takes care of Medicare patients, and then has a 24-hour, 7-day-a-week ER. And in my community, when a patient gets in trouble at a specialty hospital, they call 911 and bring them to the full acute-care hospital. They get the same payments, but when they get in trouble, they send them to the hospital.

So while I support this recommendation in theory, some of the issues that Peter brought up and what I'm just illuminating have concerns for me. I don't know how to address them, but I think we should at least have a spirited discussion.

And as Bruce just indicated, I don't think we fully understand why all this is happening. I don't think it's just a money play because your point about the for-profits would be much more engaged in that if that would be the case.

MS. UCCELLO: I am supportive of the recommendations and share the reasons that others have

already. And I think, Glenn, your bottom line, you know, that we want to pay -- peg rates to efficient providers is exactly where we want to be. And then we're indifferent on where people get the care. But right now what's happening is that behavior is being influenced by distorted incentives, and that's what's in large part causing this, and that's what we want to get away from. So I support the direction we're going.

DR. HALL: I'm also in favor of both recommendations. I would just like to kind of add two footnotes that I think I'm going to encourage us to keep our eye on if this goes forward. The most important one is that I think there are -- there's a subgroup of Medicare recipients who are very much better served by having the primary care where there are integrated services on campus. These are the sickest, the frailest, where in community-based practices to get the services might require five or six visits. It may be a small group, but it's an emerging group because of the temporary bulge in the 85-plus population. So I think we have some obligation to say, if this goes forward, are we disenfranchising to some extent a subgroup of patients that benefits so much by integrated

services.

The second one is just kind of a paradox, and that is, it has to do with teaching hospitals. In my experience, which has been -- probably my only experience clinically has been in teaching hospitals, here are a couple of paradoxes.

One of the biggest things that has occurred over the years with education of our residents is to get them out of the hospital and see ambulatory patients in the real world. This has been -- I would say, every single academic medical center in the country has been trying to put patients out in these practices that hospitals are now paradoxically trying to in a sense eliminate or bring into the system, or maybe just get paid more for the same sort of services.

At the same time, most places are farming out their clinical faculty to be in suburban locations. Why? Because a large segment of the population prefers to have accessible parking, sometimes safer environments, and kind of the patina of more of a concierge type practice.

So I don't know where that's all going. I don't think there's anything we can do about it. But I think I would emphasize that we are in a period of enormous change

here in this whole notion of the relationship between primary care doctors and specialty doctors, efficiencies of scale. And this is the right way to go, but let's take another look in a year or two down the road and see what we hath wrought, so to speak.

MR. KUHN: Thank you. The first issue I'd like to raise is kind of what I raised in part one, and that is the issue of variability. In the report there's two really good sections that talk about profitability and variability, and one looking at the types of hospitals -- teaching, rural, urban, different things like that -- and then another looking at a set of policy activities that are currently in place that are adding to that variability.

There are also some non-policy issues that have driven the variability in terms of the wage index and some recent actions in that area. CMS in particular highlighted those in terms of some impact tables in the inpatient rule this year and the outpatient rule, and I'd just like to work with you all to capture that conversation as part of the report, if we could.

The second thing is on the two recommendations. I'm pretty comfortable with the first recommendation, not so

comfortable with the second recommendation, for a couple of reasons. One, I think about six years ago CMS was looking at the distinction between emergency departments, those that were off campus versus those that were on campus. And the off-campus ones were operating in an environment that they were less than 24/7 that were out there. But it was hard for CMS to really understand the distinction between the two in terms of their overhead and activities because, from the Charge Master, there was no distinction between the types of facilities. And so they created a set of alphanumeric G codes and were then able to begin capturing the data to look at the two.

If I remember correctly, at the end of the day the distinction wasn't that great that was out there. When they actually really captured the data, the hospitals coded it and put that information in there.

So based on that experience, I'm just wondering if the distinction between those kinds of facilities is as great as we think some of the data that we have now that we're looking at just on that experience. And so that leads me to believe the on-campus/off-campus distinction that's out there.

The second issue I'm concerned about is the weights that will ultimately play out here as a result of some of the APCs as we go forward -- oh, Mark, go ahead.

DR. MARK MILLER: I ended up thinking you were saying you did not see a different between on and off campus. Is that what you --

MR. KUHN: There was a distinction, but it wasn't as great as I think some people thought originally there was. So I think the data shows us there was a bit of a distinction, but the on-campus/off-campus, yes, the on-campus there definitely was a bit difference, but the off-campus not so much as we thought. Am I being clearer?

DR. MARK MILLER: You're saying this: When I have a provider-based, hospital-based, off-campus provider, it's not that different than --

MR. KUHN: The on-campus.

DR. MARK MILLER: Than the on-campus.

MR. KUHN: Yes, it wasn't --

DR. MARK MILLER: Or, alternatively, it's not that different than the non-provider-based off-campus. You're saying that the distinction that you saw that was small was for all the providers who were off campus?

MR. KUHN: Right -- well, the distinction between the on-campus and the off-campus when it was a provider-based wasn't that great between those two.

DR. MARK MILLER: And by implication there was a greater difference between the off-campus provider-based and the obviously off-campus free-standing.

MR. KUHN: Right, a little bit difference there.

MR. HACKBARTH: The analysis you're referring to had to do with emergency --

MR. KUHN: Emergency departments, correct. And so, again, it was kind of more of a data-driven exercise that helped us kind of understand the distinctions between the two, and absent some more information here, it's hard for me to understand the order of magnitude of the distinctions that we have.

The second issue had to do with the weights, and play this out just a little bit, you know, again, thinking about unintended consequences here. So say we make this change and we go five years out. You know, one plausible scenario that could happen here or one hypothesis is that hospitals begin to reduce their charges for these set of codes that are out there, and since it's a zero sum game as

part of the process, the weights for other services, APCs, will adjust accordingly and likely go up because this set of services will go down, the others will go up.

Most of those ones that will go up will probably be more device-dependent, APCs as a result of that action. And so that could signal a couple things to the marketplace. One is those kinds of facilities that use less device-dependent or heavier utilization APCs, their revenues will go down dramatically. That predominantly will be rural hospitals as a result of that. And it could signal to the device industry that, hey, there's an opportunity here for you to adjust your prices because hospitals are going to be getting paid more, so here's a chance to change the marketplace out there. So what I'm just trying to think through here is how this policy might lead to some unintended consequences that we might go down the road.

So as a result of those two issues, I just want to think about this option a little bit more.

MR. HACKBARTH: So just a clarification on that last issue, Herb. You're saying that if we were to change the payment rates for the E&M services and outpatient departments and equalize them with the physician fee

schedule, costs currently allocated to the outpatient department physician services would be reallocated to other services and then that may lead to unintended consequences?

MR. KUHN: Yes, what I -- and, again, as I would think through this -- yeah, some of the reallocations, so basically charges would start to go down presumably for this set of E&M codes that are out there. As a result, those charges will go down, that would reflect that, as a zero sum game, charges in other parts of the APC would adjust accordingly because it's -- you know, because of the relative value since it's a charge-based system that's reduced the cost through a cost-to-charge ratio. So I think you would see others go up as a result of that, maybe appropriately, maybe by default, but I think you would see -- my guess is you would see device-dependent APCs and other kinds of APCs move up in terms of how much they're getting paid, and whether that's an appropriate new payment rate I don't know, but I think that could send some signals to the marketplace, like I say, to device manufacturers, to smaller hospitals, others that are out there.

MR. HACKBARTH: So actually the change would be in the charges, not in the cost allocation. So the reduced

charges for the outpatient physician visits and the increased charges for other things, and then through the magic of the cost-to-charge ratio, that would change other things.

MR. KUHN: On the one side, I suspect the charges would go down on the E&M codes. Whether they ultimately adjusted their Charge Master to increase charges on others, I don't know. But because of the relative value, those others would go up automatically because one set of charges is going down.

DR. MARK MILLER: And that's kind of the exchange that we had there. I can't remember which question triggered it, but it was the one that we went back and forth, Dan and I, on -

DR. ZABINSKI: I mean, I sort of view this -- you know, at the same time, they would adjust their charges, but the cost-to-charge ratios, the applicable ones, would also have to be adjusted, and I view that as somewhat of a self-defeating process. You drop the charges for the clinic visits, the cost-to-charge ratio for the applicable cost centers should go up. And in the end the estimated cost may change very little.

DR. BERENSON: Well, Herb sort of got at what I was asking about before, and it suggests with Bruce that we need to do a deeper dive in this area if we -- and I think we need to look at other patient services as well. But I think we're in good shape on this policy, and I support both recommendations, but it will get much more complicated when we look at other services where there is packaging and where it's reasonable to allocate direct costs to those services. So I think we need to get there, I think we need to understand more the issue that Herb just articulated and that we had a give-and-take about. But I'm comfortable with the policy.

I want to take my one more minute to just make a couple of comments about E&M services per se. Ariel is right when he sort of presented the theory as to what CPT coding permits, which is a recognition of severity. But when we talk within the context of the physician fee schedule, there is a lot of criticism of both the CPT code definitions at this point, the documentation guidelines. In fact, my hunch is the reason you see hospital outpatient departments with a lower profile of coding is that compliance officers are running around basically offering

great caution about upcoding for physicians who are on salary and that physicians in private practice where the income goes into their own pockets don't have those compliance officers and are maybe pushing the envelope a little more. It will be interesting to see what happens as hospitals convert -- or especially with their new docs, they're bringing them on on work productivity as measured by work RVUs, whether we see a different pattern.

So I think we have to continue doing work, and here the AHA letter I think was exactly on target. They point out that whereas hospital cost reports are based on data, the physician fee schedule is based on -- what do they call it? -- voluntary responses to physician surveys, and they suggest that maybe we're paying too low for E&M services. This isn't what we're intending to do with this policy, but if, in fact, this policy is implemented, I welcome the hospitals to the effort to try to improve our fee schedules. And I think we should not -- I guess my basic point is I don't think we should be complacent that the E&M services are being paid appropriate and at the right level.

DR. BAICKER: I'm supportive of the

recommendations. I think the framing that you laid out for the first one is really important, that you have to be able to make budget-neutral reallocations that don't then affect subsequent updates. It's a downpayment on taking back the 2.9 percent that was an overpayment and doesn't mitigate the need to take back the rest in the future.

As for the second recommendation, it makes a lot of sense to me. The equalization of payments independent of site of care makes all sorts of sense, and starting with one where we think the delivery is probably equally efficient, an E&—type service, getting them looking forward to applying this principle to other services, I think the point Jeff was raised was really important, that we need to understand how the changes that sites make to be compliant with the requirements to integrate affect different patients, and that it's hard to tell the story that those investments are affecting the quality of care delivered to this group of patients, but maybe as we start to expand this principle to other diagnostic codes, the story is different. So better understanding how the investment -- maybe harmonization of records is really important for some groups of patients, and we do want to subsidize that there, so that's something to

think towards the future.

It doesn't speak to the question of whether the level that we're paying is right. I think we're all agreed it should be the same at different sites for the same patient. What that level should be, we still have a lot of work to do.

DR. NAYLOR: I also support both recommendations in addition to the principle of same payment for same service, which I know is much more complex than it seems.

I think the idea of advancing care in environments and resources that are less costly and still clinically appropriate also is a critical dimension to this.

E&M represents a core primary care service. It's what starts and results in the decisionmaking that ensues. And I know concern has been expressed about whether or not this would thwart the integration of physicians into hospital systems, but an equal, parallel problem if we don't move in this direction of equalization is that we'll not advance integration into community-based systems that are guided by primary care.

I think that I really think the differences or absence of any clinical differences between these two

approaches right now is really important, but from the beneficiaries' perspective, the cost differential I think is really compelling and should really guide our decisionmaking.

MR. BUTLER: It's hard to disagree with the concept of same payment for the same care, so I'm not contesting that. In fact, I very much support it. And I also support the concept that we definitely should not be encouraging and maybe even blocking through a moratorium new ones, which would be one way to go to capture the kinds of examples Ron brought up with cardiology, because I think it's the growth of these that has gotten our attention, not the fact that they existed in the first place.

I think what is not like us as a group is to take a blunt instrument and say tomorrow it's cut, without fully understanding exactly where the knife is landing, and that's what I'm having anxiety about, not the principle, not a phasing, say, as Bill said, maybe five years. It's a blunt instrument, and let me just say a couple more words then.

I think as you look among -- as much as we've tried to segment profit, nonprofit, et cetera, in the footnote it also says, you know, the last 15 percent of the

hospitals is where all the action is. And even if you look at the last 3 percent, it's over 5 percent of their revenues, which means it's well over 10 percent of their outpatient revenue. And so, Glenn, you also wanted to know where would you look further. I would look at the large public hospitals in urban markets, the principal teaching hospitals of medical schools, and as you do that, I would look at the percentage of Medicaid, if you could, that go on in these places, because these are the doors that are open in the specialty care, where the teaching is going on that is providing very needed services for the disadvantaged communities. And I think if you even looked at that last 3 percent that has more than 5 percent, I think the dollar amount in there would be much, much higher. So rather than looking at number of institutions, look at the number of these dollars that are sitting in that very small percentage of hospitals. It will give you a better sense of what this means.

Does that mean that this is a subsidy for those? It is. It is. It's a different -- no doubt about it. But I think that we have to understand -- and it's not that they're going to go away tomorrow, these clinics, and it's

not that these big centers shouldn't pull out costs. But I think what you'll find is a tipping of some of these places to seek and go aggressively after the private pay more than ever before, and subtly, or maybe not so subtly, discourage those that are not paying the bills.

And so that's really my issue related to this. I think that the very short list of -- not short but, you know, several hundred institutions is where most of this is going on, and I very much would encourage some kind of transition of this as opposed to the recommendation as stated which says it's gone tomorrow.

Finally, I think let's not kid ourselves on the point -- we're really not recommending two 1-percent updates, one for outpatient and one for inpatient. This really is a -- it's less than zero for outpatient the way this is stated, which is okay. But it's a little different from just pricing accuracy that is budget neutral. We're really taking this and saying this is a savings that we want to pull out of the system, and maybe that's okay, but that's a little different from some of our repricing before, and it makes it look the way the recommendation is framed that that part is not all that clear because we just kind of tag on

this last recommendation.

So those are my points, and you obviously see I have concern, not about the inpatient one but the framing and the wording of the outpatient.

MR. HACKBARTH: So, guys, do you understand the sort of additional analysis that Peter is looking for? Any clarifications that you need? Okay.

DR. DEAN: I support both recommendations. I don't really have anything else to add.

MS. BEHROOZI: I support the recommendations with a little bit of trepidation. I think Peter expressed concern about the phase-in because clearly business models have been built around, you know, absorbing these practices, and there are some rather large hits to some -- you know, the 0.6s overall, but major teaching, it's a 1.2-something reduction in their revenue, so it seems fair to give them some time to adjust, I think.

From a consumer point of view or a beneficiary point of view, Jeff, you referred to, you know, one year or something like that, you know, you used to see Dr. X at Place A and now you see Dr. X at Place B. I've had the experience of seeing Dr. X Tuesday at this office and

Wednesday at that office, and we get billed, but not me as a consumer. My coverage gets billed differently depending on which office I see him in and on which day of the week. And so I'm very happy that Bill mentioned the impact on the beneficiary, because whether you're actually paying that out-of-pocket or whether you're paying a higher out-of-pocket, you know, even if the insurance covers -- you know, mitigates some of it, or you're paying a higher premium because more of the business is going to the more expensive place, it's absolutely unconscionable that there's no benefit to the patient, as you said, Jeff, for the different site of service for this particular service. And as Kate said, you know, we have to be cautious as we look at other services.

As far as the inpatient recommendation, you know, I am dealing daily with the travails of hospitals in New York City that can't afford to make their contributions for their workers' health care coverage to our health fund, and the number of them and the depth of their delinquencies grows every day, and I just got, you know, yelled at by my trustees yesterday about how bad we are, quote-unquote, letting the problem get. But I know it's a symptom of the

distress that our institutions are facing, and I'm not sure that the coding adjustments really, you know, seem to have helped them out so much. So the taking back, you know, I realize that overall there was an increase associated with the coding adjustments. I recognize that that's justified and needs to be taken back. But I am sort of concerned overall about the health of institutions, and I don't know whether it's in certain markets or in certain circumstances, you know, in places where there's just higher poverty in general and less social support or familial support, whatever, in general I appreciate that you sought to adjust the efficient provider group by eliminating the lowest -- the 10 percent of the lowest Medicaid share, but I'm not sure that captures the significance of the hidden costs of providing care in poor markets, you know, in overall poor markets, and I'm not saying New York or Brooklyn is the only one or the poorest one.

So I have some concerns and then somewhat offset by actually what you described, Jeff, about the fact that the margins of those 188 most efficient providers actually improved, that they really -- that does seem like it's possible to do better, you know, to control the costs

better, to keep the quality up. So I'm thinking aloud here. I'm kind of going back and forth. I do want to express the trepidation, but I think in the end, you know, it's hard to do anything other than support the recommendations.

DR. CHERNEW: I support the recommendations, and I'd like to say just a few quick things.

The first one is the recommendations are largely based on this amount of coding adjustments that we're going to get back one way or another, and if you recall, in the text there's a sort of discussion of it in a line to see our exact methodology for quantifying the coding adjustments. There was a letter that was written, which is okay. I actually haven't had the time yet to go back to that letter, but more importantly, I want to state that I think that even in the absence of that as the motivation, the level of update that one has is reasonable given the other indicators that one has said. So I don't think you need to rely -- in my mind I don't need to rely as heavily on the notion that we're just taking money back. I wouldn't take that money back, for example, if I thought the financial pressures the hospital faces were too great. And I'd take more than that back if I thought the hospitals were doing that wonderfully.

I understand and I'm very concerned with a lot of the heterogeneity issues that Mitra raised. I think she's exactly right, and I think this will be a theme for today, tomorrow, and January. We always have this problem that, unfortunately, we're looking at averages and there's going to be hospitals somewhere or other facilities somewhere or other providers somewhere that really are doing a wonderful job, and they can't make do on the Medicare payment rates. And that is a general problem. But we're never going to resolve that problem, so I'll resort to so I support both recommendations.

The last thing I would say is I think although it's not our task today and we've done this in the past and I'm sure we'll do it in the future, thinking about how these types of updates all fill together in sort of a more bundled system ends up becoming important in sort of a broader perspective. And hopefully with the flexibility of more bundled payment, even situations when particular payment -- when particular fee schedules are a little hard on certain providers, that we'll be able to find ways to find efficiencies in a broader system that will enable them to survive and provide high-quality care. And that may be more

aspirational than real, but that's my aspiration.

MR. ARMSTRONG: So first of all, I would say I endorse what I think all of us endorse, and that is this principle that we should be paying the same amount for the same services, regardless of the location, or whatever that principle was.

Having said that, I support both of these recommendations. I would have to say particularly on the second one, while Peter and several others have, I think, with the great experience they have in their practice, very eloquently argued we should be cautious about the implications, I actually would disagree with that point of view. I would say that I think we're being too conservative, and that this is a blunt instrument -- it is -- and we should be careful about the implications. But all of our instruments are blunt, and we should be careful about all of the implications. And, in fact, we know very well the implications of not making this change, and they are -- it's our responsibility to deal with the increased expenditures without necessarily getting the value back for our beneficiaries.

The last point I would make is that I think

applying this principle -- so I think we should move forward with it and move forward with it quickly, and apply it actually more quickly and more assertively to a whole number of other areas in our payment structure where I think the same principle would be relevant.

MR. HACKBARTH: Okay, thank you for the good work, folks, and now we must move ahead quickly to our second agenda item, which is assessing payment adequacy for outpatient dialysis.

Needless to say, we are running a bit behind schedule, 40 minutes, to be exact.

[Pause.]

MR. HACKBARTH: And, Nancy, you can begin whenever you are ready.

MS. RAY: Good morning. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2010, there were more than 355,000 Medicare fee-for-service dialysis patients. Total spending in 2010 was about $9.5 billion.

My presentation is composed of two parts. First, I am going to briefly describe the new payment method for dialysis services that began in 2011. Then we will proceed

with our adequacy analysis. I will provide you with information to help support your assessment of the adequacy of Medicare's payments for dialysis services. This will include an assessment of providers' capacity, patient access, and quality of care.

For the PPACA mandated report, we have looked at capacity and quality by the three rural categories. However, unlike most sectors, I have not broken out the 2010 financial data for each rural category. The new payment method that began in 2011 includes a significant payment adjustor that is expected to influence rural financial performance. Given this important policy change, we will look at financial data by the three different rural categories next year.

So -- oh, sorry. At the end of today's presentation, I will present the Chairman's draft recommendation for you to consider about updating the payment rate for calendar year 2013.

So MIPPA mandated that CMS modernize the outpatient dialysis payment method. The statute implements a longstanding MedPAC recommendation to broaden the dialysis payment bundle. Under the new payment method, the broader

bundle includes commonly furnished ESRD services, including the dialysis treatment, the composite rate services, dialysis drugs, and labs. By contrast, under the old method used in 2010, facilities received separate payment for many dialysis drugs and lab tests.

Your mailing materials include a table that compares key features of the old payment method and the new method. I am going to summarize the key features of the new method, but I am happy to take any of your questions.

So the new payment method has patient-level adjustments for age, body mass, three chronic and three acute comorbidities, and an additional adjustment for new to dialysis patients, for dialysis onset.

The new payment method adjusts for low volume. It is based on the total number of treatments that the facility furnishes in the three years prior to the payment year.

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

The law provides for a four-year transition. However, most, about 90 percent of all facilities, selected

to be paid for under the new method in 2011. The law also requires a two percent reduction in total payments in 2011.

Finally, two other issues about the new payment system. It includes an annual update of the payment rate and it links payment to quality. It is the P4P program. It begins in 2012. In 2012, it will use one clinical performance measure on dialysis adequacy and two measures on anemia, and physicians report these clinical measures on their claims.

Your briefing materials included a discussion of three potential issues about the new payment method. Our plan is to follow up on these issues once 2011 claims become available.

The first issue is the lower use of dialysis drugs under the new payment bundle. As discussed in your briefing materials, the volume of some dialysis drugs dropped in 2010 and according to industry data has continued to drop in 2011. We plan to reassess dialysis drug use once the 2011 claims become available. As discussed in your paper, if this trend continues, the savings from the declining use of dialysis drugs might be used to fund other renal-related services, including more frequent hemodialysis.

The second issue is the pay-for-performance program, the quality incentive program. In 2013 and 2014, it lacks measures holding providers accountable for the under-provision of dialysis drugs. This is a concern, given the incentive for the under-provision of services in bundled payment systems.

The third issue is the low volume adjustor. Our modeling of data from 2007 to 2009 suggests that facilities, particularly those in urban areas, may be getting the adjustment even though they are in close proximity to another facility. Medicare's dollars might be better targeted if the adjustor considered distance as well as volume. Again, once 2011 claims become available, we plan to update this analysis.

So now I would like to shift gears and move to our payment adequacy analysis. So this table describes facilities who furnished care in 2011 and their growth in capacity. The first column provides the number of facilities by provider type. Most patients receive care from facilities that are freestanding, affiliated with a chain, and for-profit. Two national chains account for about 52 percent of all facilities.

The second and third columns provide the average annual growth rates in capacity between 2006 and 2011 and between 2010 and 2011, respectively. The direct measure of capacity that we use in this sector is the number of dialysis treatment stations. Between 2006 and 2011, capacity grew by four percent per year. There was a slight slowdown in capacity growth between 2010 to 2011 compared to the five-year trend. Capacity is growing for freestanding facilities, for-profits, chains, including those chains not affiliated with the two large dialysis organizations. You will also see here that capacity is growing for both rural and urban facilities.

We use several measures to examine patient access. We look at whether facility capacity tracks patient growth. During the past five years, dialysis treatment stations have increased by about four percent per year while all dialysis patients have also increased by about four percent per year.

We also look at the number and effect of facility closures. Between 2009 and 2010, there were few facility closures. There was a net increase of about 170 during this time period. The 90 facilities that closed between 2009 and 2010 are smaller and less profitable. Our analysis did not

show that any demographic group was disproportionately affected by closures.

Another indicator of access to care is the growth in the volume of services. In this sector, one way we track volume growth is by assessing trends in the number of dialysis fee-for-service treatments and fee-for-service dialysis patients. As you can see from this chart, these two measures closely track between 2009 and 2010, as well as over five years.

Another way we look at volume growth is by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of care. In 2010, dialysis drugs accounted for about 31 percent of Medicare's total payments to facilities. So I would like to draw your attention to one drug class, erythropoietin stimulating agents, ESAs, that manage patients' anemia, which is a common renal comorbidity. In terms of Medicare's payments to facilities, ESAs are substantial, accounting for 73 percent of all dialysis drug payments and about 23 percent of total payments to facilities.

Since 2006, per capita use of ESAs has generally been going down for two reasons. The first reason is

clinical evidence that has shown an association between higher doses of ESAs and cardiovascular events. The second reason is payment. ESAs are included in the payment bundle under the new method that began in 2011.

So this graph shows per capita weekly use of erythropoietin in 2010. Per capita use started to decline in August. Publicly available industry data shows a similar decline. They report an eight percent decline for the two large dialysis chains between August to December of 2010. Our analysis shows about a nine percent decline for the two large dialysis organizations.

We look at a variety of measures to assess changes in dialysis quality. Through 2010, quality is moving in the right direction for hemodialysis adequacy, which measures how well the dialysis procedure cleans the patient's blood. Quality is moving in the right direction for anemia management. And quality is also moving in the right direction for the use of AV fistulas, the recommended type of vascular access, the site on the patient's body where blood is removed and returned during hemodialysis.

That being said, improvements are still needed in other aspects of care according to the clinical guidelines

and the consensus of clinical groups. Where we do see improvements in nutritional status, hospitalization rates, survival, they are small. This finding is similar to last year's assessment.

Moving to access to kidney transplantation, the proportion of all dialysis patients registered on the kidney transplant waiting list ranged from 15 percent to 17 percent between 2003 and 2009. Overall, the rate of renal transplantation for dialysis patients has been trending down since 2003. Between 2008 and 2009, by race, the rate of kidney transplantation dropped for whites, stayed the same for African Americans, and increased for Native Americans and Asian Americans.

I have updated the text box in the mailing materials that include the many factors that affect access to kidney transplantation. This includes patients being educated about the different renal options, transplantation and home dialysis; patients being referred to a transplant center; the evaluation of the transplant center, including the medical, economic, and psychological assessments; being placed on the waiting list; and the matching process used. It also includes differences between groups in live donation

rates, as well.

Your text box also includes the findings of a new study that reports that a national policy change in 2003 by the United Network for Organ Sharing, UNOS, in the immunologic matching process reduced racial disparities in the access to kidney transplantation. And I am happy to take any questions about that.

Moving to access to capital, indicators suggest it is adequate. As mentioned earlier, an increasing number of facilities are for-profit and freestanding. Capacity appears to be growing for the two large dialysis chains as well as the smaller size chains.

Moving to our analysis of payments and costs, as I said earlier, we have not broken down the financial performance by each rural category. We will report this information next year when we have 2011 data. At that point, the financial data will reflect the effect of the low volume adjustor under the new payment method. These 22 financial performance results are for the last year of the old payment method.

The Medicare margin for freestanding facilities for both composite rate services and dialysis drugs is

estimated at 2.3 percent in 2010. In 2009, it was 3.1 percent. The decline is mostly a function of the falling drug payment per treatment. As we will discuss on the next slide, we project that the Medicare margin will be 2.7 percent in 2012.

We see that the Medicare margin is higher for urban facilities and those located -- and those affiliated with the two large dialysis chains compared to their counterparts. As in past years, we continue to see this gap between urban and rural facilities and between the two large dialysis chains and all other freestanding facilities. Higher margin is also associated with increased volume in terms of the total number of dialysis treatments furnished. Again, we anticipate that under the new payment method, facilities located in rural areas will benefit from the low volume adjustor that increases the base rate by 18.9 percent.

So we project the 2012 margin at 2.7 percent. This includes all of the budget neutrality factors implemented in 2011. This also includes the effect of the pay-for-performance program that CMS estimates will reduce total payments by 0.2 percent in 2012. This also includes

the payment updates in 2011 and 2012.

So this summarizes our adequacy measures. The only thing that is new on this slide that I would like to point out is that in 2013, the year that your recommendation affects, the pay-for-performance program, CMS estimates that the payment reduction in that year will be 0.3 percent.

So this leads to the Chairman's draft recommendation, and I will read it. The Congress should update the outpatient dialysis payment rate by one percent for calendar year 2013. This will result in a slight decrease in spending relative to current law. We do not anticipate that this recommendation will adversely affect beneficiaries. It will increase financial pressure on some providers, but overall, a minimal effect on providers' willingness and ability to care for beneficiaries is expected.

That concludes the presentation and I look forward to your discussion.

MR. HACKBARTH: So, and Nancy, I have a clarifying question. So I am projecting the margin for 2012. What rate of cost growth did you assume under -- now that people are under the new payment system? Did you assume that cost

growth went down or stayed the same or what was the assumption there?

MS. RAY: I used providers' historical cost growth in this area for both looking at composite rate services and also looking at dialysis drugs.

MR. HACKBARTH: I remember last year when we talked about the update for ESRD, we took note of the fact that a large percentage of the facilities -- and ultimately it turned out to be 90 percent -- elected to skip the transition to the new payment system and go to it immediately. We inferred from that that they saw opportunities to benefit under the new payment system and reduce costs and increase their margins.

So given that, would you say that, assuming historical rates of cost growth for our projection is probably a fairly conservative assumption?

MS. RAY: Yes, it is. Now, in addition to that, we have included in 2011 a very conservative behavioral offset, and this is based on the industry data that they report for the reducing, just looking -- they have just reported on epo utilization between January through June of 2011.

MR. HACKBARTH: The 2012 estimate does include --

MS. RAY: Yes.

MR. HACKBARTH: -- an addition for the epo change --

MS. RAY: Yes.

MR. HACKBARTH: All right. Thanks.

Clarifying questions. Scott.

MR. ARMSTRONG: Just two brief ones. The drop in the erythropoietin is pretty spectacular after the payment structure change. Are we confident that the quality measures are picking up any downsides to such a change in the use of that drug?

MS. RAY: Right. That is a good question. I have begun to look at whether or not there are any changes in rates of hospitalization in 2010 and I have just started that analysis because the data came in a little bit late. But looking at unadjusted rates of hospitalization, they have remained about the same between 2009 and 2010. But I am hoping that I will be able to come back with more information with you on that.

MR. ARMSTRONG: Okay. The other question I have, I do not know this industry very well, but it seems when you

go to a payment change like this, the providers are going to be focusing both on utilization of services within a payment bundle, but also the cost per unit of service will be very important to them, too. And it seems like with the two dominant systems owning a lot of the supply chain, I wonder how much we know about the relative cost per unit of service between those two systems and the others and whether we look at that level of analysis.

MS. RAY: I can bring you that information back next time. I don't have that in front of me, and honestly, I don't -- I'd like to bring that back next time.

MR. ARMSTRONG: Okay. It's just -- it may not be worthwhile, but it could be just really interesting to break down, because the margins are expected to be far less for those independent facilities. I'd like to know, is it just because they are not able to manage care as effectively, or is it because they are experiencing really high cost per unit of service relative to the rest of the industry.

MR. HACKBARTH: Scott, so let me distinguish between two types of component parts to the service. One is, for example, drugs, which all of the dialysis facilities are buying from independent providers. The advantage,

potential advantage of the big chains is that they've got more purchasing power leverage.

Then the second category of services would be services that the big chains -- they're vertically integrated and they're actually producing the services themselves. They're using some of the services that they produce themselves and they're selling some to other dialysis facilities. And what I hear you suggesting is that on that second category, they may be saying, well, we charge ourselves X dollars and we charge an independent non-member of our chain X-plus-ten percent or 20 percent for that service. Am I understanding your question correctly?

MR. ARMSTRONG: Yes, you are also making it clear that I don't really understand how this industry works that well. But if we're concerned about the gap in relative margins between those two systems, it just seems to me we ought to understand a little bit more about why and how our payment structure could exacerbate or mediate some of that difference.

MS. RAY: I just also want to point out that there are cost reporting rules, and I will get back to you on the specifics of these, regarding what facilities -- how

facilities are required to report the costs even when they do manufacture the hemodialyzer and so forth.

And the other item is that the cost information -- for the composite rate services, so that is the actual dialysis treatment, that is under a prospective payment. But, again, before 2011, the drug costs are separate. So there are differences between the different chains and their prescribing behavior, even with separate payments. So there are just those two caveats.

MR. HACKBARTH: Mike, clarifying questions.

DR. CHERNEW: I just wanted to clarify Scott's question, which is when you look at the 2010 data for the epo drop, be clear to look after the actual drop, because a lot of 2010, it looked like it was pretty stable from the graph and it really just fell off at the end. The sample size, I think, would be big enough for you to be able to look at not all of 2010 versus 2009, I would say the end of 2010 when there was this drop-off in use.

MS. RAY: There was a decline in 2009, but it just -- again, you don't have the 2009 data here. This is just 2010. It's just not as steep a decline. The epo use has been gradually going down beginning in 2006, generally. But

where you see the biggest decline is for the last four or five months of 2010.

You know, one explanation for that could be that providers, both the physicians and the facilities, are beginning to titrate their patients differently in anticipation of the new payment method. That is not something that could be just -- my understanding is that that is not something that can just be started right beginning in 2011.

DR. CHERNEW: I guess my comment would be, you could envision a decline from 2009 to 2010, and I have no clinical basis for saying this, as being from overuse to the right use. You could envision a decline further from being from the right use to too little use. And if you look at the slide that you had, which was number -- whichever it was -- that one -- you can see that, really, starting around September of 2010, there was a ten percent reduction in use. And it might be that that reduction in use had a different effect than a comparable reduction in use starting at a much higher point. I mean, I think that many people would have said, and I don't know this area well enough to be one of those people, that there could have been overuse in the

system beforehand. But that certainly doesn't mean that if there was no effect getting down to 20,000, that getting down to 18,000 will be fine.

MR. HACKBARTH: They did go from an appropriate level of use to a level that is too low for this particular component part. It would show up in terms of increased anemia, is that right? Is that what --

MS. RAY: It would --

MR. HACKBARTH: Would that be the quality measure that would --

MS. RAY: Right. Right. Right. I mean, it could show up in the reported hemoglobin levels. It could show up in the rates of blood transfusions.

MR. HACKBARTH: Uh-huh.

MS. RAY: And it could show up potentially in the rates of hospitalization.

MR. HACKBARTH: And how fast would that data be available, both to us and to them to know that, oh, wait a second, I have gone too far?

MS. RAY: Right. Well, we have some of the 2010 data to look at rates of hospitalization right now.

MR. HACKBARTH: So the lag for us is substantial.

MS. RAY: Well, there is a little bit of a lag for us, yes. Yes. That being said, I would like to -- I mean, I am planning on bringing back the rates of hospitalization at the January meeting. I don't know if the data on blood transfusions that I need, the 2010 data, I don't know if that will be available by January.

MR. HACKBARTH: Okay. Herb.

MR. KUHN: One other data set that maybe you could bring back to help us look at this is the hematocrit monitoring program that CMS has and kind of what that looks at, because I think Mike is right. I think there was some real concern that -- under the old payment methodology when it paid separately for drugs, there was some use of epo at kind of the upper bound of the safe range. And so CMS put in place a hematocrit monitoring program that began the glide path to move it forward, this new payment system. It might be in the right range. So I think that would be another indicator if we could get that information to look at, too.

MS. BEHROOZI: Yes. Actually, as a direct follow-up to that, you say in the paper, Nancy, that for the first six months of 2011, there was another four percent decline

in the use of ESA, right, so we don't even know if they've stopped dropping yet, right?

MS. RAY: Right. And again, that is according to the industry data that's publicly available.

MS. BEHROOZI: Yes. So as far as, like, whether we've reached the right level or whether payment policy is continuing to drive a further decline --

MS. RAY: Right, but --

MS. BEHROOZI: I am sorry. So the first six months, is that because that is the only data that you have? Could it be continuing to decline but we don't have data yet for the last six months, or did it stop declining?

MS. RAY: The last six months of -- I don't -- I do not have data yet on that.

MS. BEHROOZI: Right.

MS. RAY: I do want to reiterate what other Commissioners have said, though. Use of erythropoietin has been steadily increasing over more than ten years, substantially, and there has been several new clinical studies that have showed that higher use of erythropoietin is linked to increased risk to cardiovascular events.

MS. BEHROOZI: Yes. I remember when you told us

about that last year. I guess it's just the susceptibility, whether the over-prescription or the immediate cutback on prescription to payment policy is pretty dramatic here, you know. The clinical evidence seemed to have a little less of a dramatic impact.

One other question I wanted to ask was about physician joint ventures with dialysis chains. In the Appendix, you talk about that, but it wasn't clear to me whether you had data on it or whether that was sort of anecdotal. Do you know what the extent of it is, like what percentage of --

MS. RAY: We do not have -- unfortunately, we do not have facility by facility data on the extent of physicians' financial interest in a given facility. Some of that information is reported on the cost reports, although it varies in the reporting. But we do have a recommendation -- the Commission has a recommendation for the collection of such information and that would enable us to look at -- if we had facility-level data, that would enable us to look at, for example, physician prescribing of dialysis drugs and financial ownership, for example.

DR. BERENSON: Yes, in the chapter, in what you

sent us -- you didn't talk about it -- you had a pretty impressive text box on the use of more than three times a week hemodialysis and reported two clinical trials -- and I've asked about this before -- which seemed pretty positive in terms of their clinical outcome. So a couple of questions.

Did those studies at all look at utilization of services along with clinical outcomes or cost? Do you know?

MS. RAY: Look at what kinds of --

DR. BERENSON: Hospitalization rates, things like that, whether the lower rates of hypertension, lower cardiac mass results in less congestive heart failures and, therefore, less hospitalizations, et cetera.

MS. RAY: Right. Yes. It did. It did. They did. They looked -- they looked at the left ventricular mass, which show favorable outcomes with more frequent hemodialysis. They also looked at -- for some of the secondary outcome measures, and I will come back to you next month with more specifics about this, but some of the secondary outcomes looked at use of hypertensive medications and phosphate finders. And at least for the -- well, no. For both of the trials, for the daily -- for the short daily

and the nocturnal, I believe there was better control of hypertension and the phosphorous.

DR. BERENSON: Where I'm going is -- I mean, it seems -- I guess my question would be, is this data compelling enough so that we should be thinking about policy? You've identified an obstacle as Medicare payment policy that limits payment to three times. Are we ready to sort of take that on and, I guess, to support such a move if we had information about that there's actually offsetting savings, for example, in decreased hospitalizations, that would be helpful. So I guess, is the data pretty compelling at this point that we should be looking to change our payment policy, in your view?

DR. MARK MILLER: She's looking at me now, and I'm -- I think the way we think about this -- Nancy, feel free -- that you have these two clinical trials that came through pretty strongly looking at the results that we walked through here. I'm not so much clear on hospitalization and that. It seemed more like it was function, phosphates, that type of thing.

Then there was the one where it didn't show that much effect, and I think what I would -- the way I would

answer this question is I feel like we're kind of on the cusp of a change here, perhaps, in the clinical world, and maybe what we need to do is kind of reach out more broadly, bring more clinical research in and see how strong this is. Sometimes when you bring people in, sit them around a table and start talking about it, you get differences of opinion among the researchers and that type of thing. I don't feel strong enough and versed enough to say, okay, the evidence is in. Let's go. But it's probably enough moving in that direction that we ought to be talking.

The other thing is also modes, you know, encouraging more -- if you're going to do it more frequently, more home dialysis, that type of thing. And so I think we're at the point in the research where we probably ought to be having that conversation.

MR. HACKBARTH: So let me just make sure I have it straight. So under the new payment system, it's still a bundled payment per dialysis session and we retained the three times per week maximum. And so the policy question here would be whether to remove or somehow modify the three times per week maximum. Do I have this correct?

MS. RAY: Right. The FI medical directors do

provide exceptions and pay for a fourth treatment per week when there's medical reasons to do so, for example, fluid overload. I mean, there's various different options you can think about if, you know, if we were to consider moving forward on more frequent hemodialysis.

One is going back to when we recommended a modernized payment system, is using a monthly payment bundle instead of a per treatment payment bundle --

MR. HACKBARTH: Right.

MS. RAY: -- and that would certainly give providers more flexibility in furnishing care.

MR. HACKBARTH: Right. Okay. Clarifying questions. Herb.

MR. KUHN: Two questions on page six, where you talk about issues with the new PPS payment system. The second dot point where you talk about the absence of measures for the under-provision of dialysis drugs, and we've had a little bit of a conversation on this already, but what I was curious about is that with this new measures application partnership that was part of the ACA and CMS puts forth measures that they want to use in the out-years, do they have additional ESRD quality measures in the queue

that they're asking for the consensus process to start reviewing to get ready to deal with some of the issues that you're referring to here?

MS. RAY: Okay. So what happened in -- okay. So in 2012, there was a measure -- there was a specific measure for ESAs that looked at the percentage of patients with a hemoglobin under ten. Because of the new clinical information and the change in the FDA policy for ESAs, they removed that measure because they could not -- based on the clinical evidence, CMS determined that they could not come up with any specific hemoglobin level, the lowest level that is safe. So that is why they removed that measure from the 2013 and 2014 pay-for-performance programs.

MR. KUHN: Thank you. That is helpful to understand that distinction there.

The second question I have, it's not on the slide here but it was in the written material, and that was an issue that the industry had raised in dealing with the case mix adjustor or the comorbidity adjustor. And as I understood it right, is that they -- by gathering that additional information, obviously, it helps their payment, but some of those diagnoses or some of that information

comes from a separate physician office and the ability to collect it is very difficult. When they do collect it, they presumably have to rebill. That means that Medicare has to process a second claim. That means they have to go through a second claim process.

Have there been any recommendations on how that process could be more automated, other than when we get the electronic health records, but is there a better way for centers to get that information and exchange that kind of data on patients?

MS. RAY: Well, I mean, certainly, encouraging the electronic exchange of medical information, which I think the Commission has discussed under other venues --

MR. KUHN: Right.

MS. RAY: -- would certainly help out here. I think it remains to be seen with this issue whether or not this is indeed a problem. And again, we will know this once we begin to analyze the 2011 data.

DR. MARK MILLER: And again, just to that end, I was trying to quickly remember, we sort of ended the paper by going through a list of issues, is that right, or was that just an internal conversation?

MS. RAY: Yes, that was sort of a --

DR. MARK MILLER: Okay. All right.

MS. RAY: But, no, but in the paper, it wasn't at the end of the paper, it was more towards the beginning of the paper --

DR. MARK MILLER: No wonder I couldn't find it just now.

MS. RAY: Yes.

DR. MARK MILLER: Anyway, what I want you to know is that as a -- we know this PPS is going into effect. We know a number of issues have been raised, both by the industry and others about what is going on, and Nancy has a list, apparently towards the front of the paper, of the issues that we're going to start trolling through and you'll see come in front of you, and this is one of them. I don't think we have a fix right now, but we are aware of it. And there was a list of issues that came up.

MR. HACKBARTH: Bill, clarifying questions.

DR. HALL: Yes. In the text, Table 1 gives an age distribution of dialysis recipients, and this is one thing different than a lot of Medicare in that there's a very wide age distribution, starting at age ten all the way up to

infinity. Roughly half of all of the dialysis recipients are under age 65, conventionally thinking of where Medicare starts.

Is there any value in trying to parse out whether there are substantial differences in the population above and below age 85? By the way, half of those people above age 65 are above age 85. This could skew things in a variety of ways -- use of drugs, consideration for renal transplantation, and the big Kahuna, which I don't think we're going to be able to get at, is quality of life, which is a very sticky thing to look at with dialysis. And I don't know exactly what those elements would be, but it just strikes me that it's very hard to lump this population into one piece.

And the only other point I would make is that I think the slide on erythropoietin usage and dropping is actually more a triumph of good science rather than any nefarious kind of plot to game systems. I think it just proves it didn't work and did some harm. And a lot of that data came to bear in 2009-2010.

MR. HACKBARTH: Cori.

MS. UCCELLO: The discussion of issues is on page

ten and 11, and I have --

DR. MARK MILLER: Thank you, Cori.

[Laughter.]

MS. UCCELLO: Well, I'm not trying to show you up. I just have a related question to that section, so --

[Laughter.]

DR. MARK MILLER: We both --

MR. HACKBARTH: But you did show him up.

DR. MARK MILLER: We both know what's going on here.

[Laughter.]

MS. UCCELLO: Aside from the three issues mentioned, there is an issue that industry representatives are concerned that they often lack the necessary information to bill based on the comorbidities, and is the issue that they don't know the comorbidities or is the issue that they need some kind of certification or something that they can't get and so can't submit?

MS. RAY: Right. According to industry, they know about the comorbidity but they actually need documentation from the diagnosing provider, whether that be a hospital or another physician office, to be able to bill for that. And

again, the concern is that, well, the costs of collecting that information, you know, may exceed -- the labor costs, in particular, will be too much and that facilities will not bill for these different comorbidity adjustments.

That's the concern. Again, we do not have 2011 data yet to know whether or not this is actually playing out and whether or not there's differences across the different provider types.

MS. UCCELLO: The bottom line is that they do know their patients and the comorbidities that they have.

MS. RAY: That is what they tell me, yes.

MR. GEORGE MILLER: Yes, first on Slide 15, could you tell me if you know in the urban and rural baskets the breakdown of how many of those may be hospital provided versus freestanding, particularly the rural area, where the margin is negative?

MS. RAY: This table is just for freestanding facilities.

MR. GEORGE MILLER: Oh, only for freestanding. I'm sorry. I'm sorry. Then my question is, why do rural providers have such a negative Medicare margin, and the fact that it's freestanding makes my question even more curious.

MS. RAY: Well, they tend to be lower volume than the urban facilities and that has a huge effect on their financial performance in terms of the volume and economies of scale. Also, since 2006, CMS has been decreasing the wage index floor to try to ultimately eliminate it.

MR. GEORGE MILLER: Right.

MS. RAY: So that has also affected the financial performance of facilities in rural areas.

MR. HACKBARTH: These data are 2010, so these are before a low volume adjustment --

MR. GEORGE MILLER: Adjusted --

MR. HACKBARTH: -- and we'll have to wait to see the magnitude of the effect of the low volume adjustment on the rurals.

MR. GEORGE MILLER: Okay. And this information in the text, again, I want to commend you and the staff for breaking out the demographic information, but I am drawn to, and I mentioned it earlier, about the kidney transplantation issue and I'm just struck in the text, the difference with minorities, particularly African Americans, who make up about one-third of all ESRD patients but receive only about a quarter of the transplants. Do you know if there's any --

and I read in the text the information about some of the reasons why they are not, but do you know if there are any studies that help to increase this? And I'll cover the next part of my question in round two, but do you know if there are any studies that help to increase minority participation in transplant programs to make it more effective?

MS. RAY: You know, I'd like to come back and answer that question next time, but one item that might have an effect, at least in the beginning of the process on the education of patients, Medicare has begun to pay for pre-ESRD education in which patients are supposed to be educated about there are different rental treatment opportunities, kidney transplantation as well as home dialysis. So there is, you know, effect on at least one item that Medicare is now doing to perhaps at least educate all patients about the different renal treatment options.

In terms of other, I guess what you would call quality improvement programs being done by other actors, I'd like to come back to you in January with that.

MR. GEORGE MILLER: Okay. I'll wait for the rest for round two, then. Thank you.

MR. HACKBARTH: Clarifying questions.

DR. CASTELLANOS: I'm sorry. Bring Slide 11 back. We really did a lot of talking on that. Both Bill, Mike, and Scott did it. I just think this is a good example of appropriate guidelines based on good clinical medicine and financial support. So I really believe that appropriate guidelines work.

I'm looking forward to your follow-up over the next couple of years of data on this, but I think this is just a good example and I wanted to clarify that.

MR. GRADISON: And on that point, Ron, I would add that I really don't know of an area that we'll be considering today where there is more useful quality data that's really directly appropriate. I mean, this is a very narrow thing and the data -- it can be improved. There are additional things that are needed, but it's excellent.

I used to do some work with this group and I just want to mention one thing because it bears upon the low volume adjustor. I often wondered, why are the centers so small? I mean, once you get above 15 or 20, you don't find very many. And the reason is they tend to locate them in terms of the driving distances, how long does it take people to get there, because they have got to come there three days

a week for hours and hours and all that and it's just harder to do that in a rural area and much easier in an urban area. But that's why you might have multiple centers in a big city, lots of them, under common ownership. And that's really, I think, the clinical reason.

My question or comment has to do with mortality. It's been a while since I've checked this. At least the last time I was doing some work with them, the average annual mortality rate of this population was about 20 percent. Quick question and then a follow-on. Is that still roughly what it is today?

MS. RAY: [Nodding.]

MR. GRADISON: Okay. I'd like to see if you have any data that we could have at a later time of mortality broken down in these different categories that you use, if it's available. Maybe it's in here and I've overlooked it.

MS. RAY: By patient or by providers or both?

MR. GRADISON: By provider groups --

MS. RAY: By provider groups --

MR. GRADISON: -- rural, urban, the size of the center, publicly, the big two, Fresenius and DaVita versus everybody else, and whatever you've got on mortality.

MS. RAY: Right. Now, your paper does include mortality by the different providers, by the different chains, not -- the urban and rural, that would be a little bit tougher and probably not for this cycle, but perhaps for the future.

MR. GRADISON: It would be helpful.

MS. RAY: Yes.

MR. GRADISON: Thank you.

MS. RAY: Okay.

DR. BORMAN: Just a sort of question and comment about Slide 12, just because sort of philosophically it relates to quality measures generally. If you look at the dialogues within AV fistula measure, we sort of assume with quality measures that we can almost always get pretty darn close to 100 and that that's our goal. This is an example of a measure that there's a finite number of patients that will never be candidates for a primary AV fistula, and so I think it will be important at some point to know what is that rate limiting number so that we aren't confused as we look at the graphical presentations of the metrics and as we think about them.

MR. HACKBARTH: That's a good point. My

recollection, though, is that other countries have quite high rates relative to ours on use of AV fistulas. Do I remember that correctly, Nancy?

MS. RAY: I would need to go back and double-check on that. My -- what I will say with respect to AV fistulas is that while we have seen some movement, it may not be as much as we would like. In 2014, however, one of the P4P measures will be on use of AV fistulas and use of catheters. So we may begin to see even more movement there with that incentive.

DR. BORMAN: I think the issue, though, is not so much -- and I don't want to get too deep into the technical details -- but of catheters versus AV fistula, because catheters are temporary. AV fistulas are meant to be a long-term access item. And the competitor there is a graft fistula which sometimes is impossible in patients initially for a lot of reasons, like they've had a lot of other procedures and tests and venipunctures and things that have just made their veins unsuitable for a primary AV fistula. And so I think that -- and again, it's just as a philosophical question that there may be some metrics like this one where we need to know what the upper bound is just

so we can know what's reasonable improvement, and that's the only issue I'm raising related to that.

MR. HACKBARTH: That's a good point. Yes.

I have two clarifying questions, Nancy. Could you put up 11, please. So we've had some discussion about how the shape of this line has been influenced by good clinical evidence. I agree with that.

But concurrent with this, there was also a new payment system coming which changed the incentives. So we've got potentially both a clinical and a payment effect intertwined here. The clinical information -- this is 2010 -- the clinical information -- the debate I remember vaguely, very vaguely, about the appropriate level to shoot for actually predated 2010, if I remember correctly.

DR. MARK MILLER: Right.

MR. HACKBARTH: So the clinical information was out there before this graph. This almost seems to me more likely to reflect the anticipation of the payment, just because it's a 2010 graph. Any reaction to that?

MS. RAY: That may be true. I mean, again, I do want to point out that, in general, per capita use has been declining since 2006.

MR. HACKBARTH: Yes. But then this curves --

MS. RAY: Right. Yes. Yes.

DR. MARK MILLER: And as I vaguely remember it, too, there was -- even before it moved into the PPS, there was a payment policy tied to the dosing, as well.

MS. RAY: Oh, yes. Yes. I mean, CMS has had their --

DR. MARK MILLER: And so I think your --

MS. RAY: -- ESA monitoring payment policy, yes.

DR. MARK MILLER: -- your broader point is that it was both clinical and payment --

MR. HACKBARTH: Exactly.

DR. MARK MILLER: -- throughout the entire --

MR. HACKBARTH: [Off microphone.] It wasn't one or the other. It's the combination of the two.

DR. HALL: But one might have driven the other. The early studies on erythropoietin doubting the efficacy might have actually informed people of our policy.

MR. HACKBARTH: Oh, absolutely, unquestionably, in terms of the --

DR. HALL: Call me crazy, but --

MR. HACKBARTH: -- the first step of changing

payment policy on epo use. The broader change of going to a bundle, that predates all of the discussion, the clinical discussion about overuse of epo. That was -- in fact, we first started talking about that back in, what, 2002 or something, a long time ago.

The other question I had, Nancy, has to do with concentration here. We've got these two very large for-profit chains that have bought up a large share of the freestanding industry. My recollection is that all of those mergers have to go through pre-merger review by FTC or the Justice Department. Just for my own edification, I wonder if you could get some information about how FTC or DOJ looked at the industry and the analysis that they went through.

From a strictly lay perspective, this degree of concentration and now vertical integration is striking to me. Apparently, the relevant antitrust authorities said they thought it was okay. I'd like to learn more about why they thought it was okay.

MS. RAY: Right, and I don't really have that much to add on this, and we can come back to you, hopefully.

MR. HACKBARTH: Yes.

MS. RAY: But what I will say is with some of the mergers, in order to go through with the acquisitions, they have had to -- what's the right word --

MR. HACKBARTH: Divest.

MS. RAY: Yes, that's the right word -- a certain number of facilities, and then those facilities become a new little chain, for example, that that can happen, so --

MR. HACKBARTH: So I'd just like to learn more about how the relevant authorities looked at this.

Okay. Round two, Scott, and again, please let us know what you think about the draft recommendation.

MR. ARMSTRONG: Right. Actually, no other questions, a little more to add. The analysis is going in a direction, I think, that is sound. I thought we asked good questions. I am in favor of this recommendations, but I think we have some pretty good questions that we will want to see some of the answers as we tee it up next meeting.

DR. CHERNEW: I am fine with the recommendation.

MS. BEHROOZI: Like with the hospitals, I think it would have been helpful for me to see the distribution of margins, you know, by quintiles or quartiles or whatever rather than just by characteristic since there seems to be

homogeneity here, as you have pointed out, the two chains.

So with respect to the curving down on the ESA utilization, like I said, I am struck by the fact that it has continued to go down by another four percent in the first six months of this year when the clinical evidence was out a while ago, as you said, Glenn, on the two tracks. It seems like that payment track is having pretty significant influence and it's distressing, as Mike started out by saying, are we getting to the right amount now? Are we going below the right amount now?

If we were above the right amount before and there's this clinical evidence that it was harming patients and there's a lot or it's common, as you say, at least anecdotally, that there is ownership interest by the people who are responsible for doing the prescribing or even sending the person in for dialysis, you know, choosing the point at which they go into dialysis or whatever, I think we really need to explore that more as we do on the imaging side or in other settings.

I mean, as people are becoming more concerned about the harm to patients from overexposure to imaging, not just the harm to the Medicare program in terms of paying for

unneeded care, I feel like do we have a good example in hindsight to be looking at in terms of exposure of patients to harm by virtue of distortions in the payment system and ownership interests.

And one thing that you mention in the paper at one point -- when you first, I guess, talk about lower use of dialysis drugs, or the second time, I can't remember -- you refer also to Vitamin D supplements or something like that, something else besides ESA that seems to have shown a decline, while something else, iron supplements or something, went up. Maybe if there is a fully picture of the prescribing patterns that seem to be influenced -- that could be influenced by the bundling of the payment, that might be instructive in sorting out the clinical component with respect to ESA from the impact of the payment system.

Otherwise, I don't see any reason not to support the payment recommendation, basically.

DR. DEAN: Yes, I support the recommendation.

It just occurred to me, Glenn, with your comment, I wonder if the FTC approach may well be, since this is essentially a single-payer program with basically administered prices, maybe they're not as worried about

consolidation. It's just a thought.

MR. HACKBARTH: Nancy, what percentage of the revenue for the industry comes from Medicare?

MS. RAY: Revenue?

MR. HACKBARTH: Yes. There's some relevant information in the paper. I can't remember it off the top of my head.

MS. RAY: Well -- right. No. But, I mean -- most patients are Medicare, but there are roughly maybe seven to ten percent -- seven, ten, 12 percent of patients have Medicare as a secondary payer. They are -- and they are employer -- they are covered for their prime -- the employer insurance program.

MR. HACKBARTH: So there's a period, a waiting period before they become fully eligible for --

MS. RAY: Right. So for the first 33 months, Medicare is a secondary payer, and in that instance, commercial payers do, on average, at least information that we've been able to get from the SEC filings, pay more than Medicare does. So the split in terms of patients between Medicare and non-Medicare is different than in terms of the revenues. So I don't want to misspeak, so I'd rather just

come back to you next month.

MR. HACKBARTH: So I just wanted to make the point that it's not totally a single payer system. Yes.

MR. BUTLER: I'm okay with the recommendation.

DR. NAYLOR: I am, as well. Look forward to the additional feedback.

DR. BAICKER: I support the recommendation and second the idea that any oblique information we can get about appropriate levels would be helpful.

DR. BERENSON: I support the recommendation.

MR. KUHN: I support the recommendations.

DR. HALL: The same. I just wanted to compliment you on the written material we got. I really learned a lot from that.

MS. UCCELLO: I support the recommendation. One of the themes over the next day and a half is payment adequacy by urban and rural and how low volume can be a bigger driver of payment adequacy rather than an urban-rural split. So I think it's good that this has the low volume adjustor, but it seems like it may not -- that it, too, may be too blunt with respect to the proximity of other facilities. I think Bill made a good point, is you want

these to be close to people, so you don't want to have too kind of narrow a mileage range. But if 25 percent of low volume facilities are within 1.2 miles of the next one, that seems to be a lot. So I think as we move forward on this, looking at that more could be helpful.

MR. GEORGE MILLER: Yes, I support the recommendation and echo what everyone else has said, but I do want to focus on the issue I brought up earlier and maybe for future meetings, to talk about a way to incentivize a more equitable distribution of the transplant issue or make it a quality measure in some form or fashion that rewards excellence and moving toward that goal versus penalizing someone for not doing, but look at it from a positive incentive or reward effort doing that job.

And then secondarily, just as a comment about the drug issue, I just raise the issue, while I understand the bundling and putting everything together from a price standpoint, my question would be if that may not incentivize some free enterprise folks to do less because that bundled payment has the drugs in the bundled payment.

MR. HACKBARTH: You know, there isn't a perfect payment system --

MR. GEORGE MILLER: Right. I understand.

MR. HACKBARTH: If you pay fee-for-service or some variant --

MR. GEORGE MILLER: I understand that.

MR. HACKBARTH: -- you get more of everything, and if you have a bundled payment or a capitation of risk, is you'll get under-service.

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: As I think Bill Gradison mentioned earlier, one of the reasons that, early on, back in the early 2000s, MedPAC recommended going to bundled payment here is that this is an area where there are pretty good quality measures that we can look at for under-service, and so get closer to that appropriate balance of incentives.

MR. GEORGE MILLER: However, we still have --

MR. HACKBARTH: Always need to be vigilant.

MR. GEORGE MILLER: Yes. Yes. Yes. Okay. Thank you.

MR. HACKBARTH: Bruce.

DR. STUART: I support the recommendation.

DR. CASTELLANOS: I support the recommendation and look forward to the further data.

MR. GRADISON: Me, too.

DR. BORMAN: I support the recommendation. I want to thank Nancy for having included the transplantation information over several years, because there was a point where we didn't talk about that and I think that's been helpful just in informing the process a little bit, because now we're bumping up really now against the organ donation issue, which is obviously not an exclusive one to the Medicare program.

And I would only make the note that on the Vitamin D drugs, the bone disease in renal failure is a multi-factorial one and we want to be a little bit careful about drawing big conclusions from just snapshot pieces of it, because the management of their bone disease and related diet and a lot of other things will come into play there, not that it's not a good measure, and that we ought to identify metrics if the drugs are decreasing. Are we maintaining bone health? But it's not quite as clean as the ESAs and hemoglobin.

MR. HACKBARTH: Thank you, Nancy. Well done.

Now we will have our brief public comment period.

The ground rules for the public comment period are

please begin by identifying yourself and your organization, and limit your comments to no more than two minutes. When this red light comes back on, that will signify the end of your two minutes. And because we're so far behind schedule, I'm going to have to be very strict in enforcing the two minute limit.

Thank you.

MS. UPCHURCH: My name is Linda Upchurch, and I'm here today as a representative of NextStage Medical. We're a Massachusetts-based device company and the leading innovator of home hemodialysis, so I appreciate the opportunity to share our observations with you, and especially the comments that have already been made. Obviously, there's been a lot of discussion about home hemodialysis among the group.

More frequent home hemodialysis, currently at about 2 percent of the dialysis population, is offered in only 15 percent of the dialysis centers. It's grossly underutilized, relative to what experts believe is appropriate and versus what physicians and nurses report that they would choose for themselves or family members who may face kidney disease.

I'd like to briefly address three topics: clinic evidence; blatant disparities in access; and the impact of the bundle.

First, the clinical benefits of more frequent home hemodialysis. They're well documented, including three recent publications in the New England Journal of Medicine, among a host of peer-reviewed articles in journals over the past 12 months. I know you've looked at some of them, but the compendium of the data is huge and quite compelling.

These peer-reviewed studies have clearly demonstrated improved patient survival, cardiovascular comorbidities, reduction prescription drug requirements, improvements in nutrition status, and greatly improved patient experience factors such as time to recovery, fatigue, depression, and sleep quality. This is a life-changing therapy and patients will readily attest to this.

In addition, USRDS data shows that home hemodialysis patients are more likely to be listed for transplant and to receive transplantation when compared to their same counterparts or stringently matched counterparts in the in-center population.

This therapy truly aligns with the quality

patient-centered goals of Medicare.

Second, there are blatant disparities in access that remain. Simply stated, home hemodialysis patients as compared to the general ESRD population tend to be more likely to be male, disproportionately covered by commercial insurance, and African Americans are significantly under represented in the population. We routinely hear from patients that they are denied therapy because Medicare is their primarily payer.

Finally, MAC payment practices differ and these differences were shown to impact patient access in a recent study by the University of Michigan, which presented at the ASN Congress in November. Patients should not be denied access to their therapy of choice because of their gender, race, insurance coverage or zip code.

Third, the bundle does not materially increase patient access to home hemodialysis. Centers offering the therapy and the patients trained on home hemodialysis have not increased to the level which CMS has expected or which is clinically justified. We believe this is due to the remaining issues with how payment is administered.

I know I've reached my time.

MR. HACKBARTH: Yes, and it's important information and please use our website. We have a place where you can file comments on our website. And I know you've talked to our staff.

MS. UPCHURCH: We have.

MR. HACKBARTH: We appreciate your taking the time today.

MS. UPCHURCH: Thanks for the time. I'd be glad to answer any questions.

MR. HACKBARTH: Thanks.

MS. SMITH: Thank you, it's Kathleen Smith with Fresenius Medical Care.

I'd like to just comment on the comments that went around the table, just a few of them.

Slide 11 or 10, the ESA utilization graph, I just wanted to comment that the payment system has the quality incentive performance program built into it. So therefore, 2010 was the performance year for the first year of the QIP implementation. So payment reductions will take place in 2012, based on the 2010 performance.

So while there was a forthcoming change in payment system, there is the arrester or the driver on the other

side to maintain quality where it needs to be.

So I hope that alleviates a lot of the concerns that I heard around the table.

Herb, to your question, there are five additional measures already ready to go, and there are five or six -- I think they announced a new pediatric TEP being convened by CMS. So there's active and a lot of work going on with regards to measures for dialysis.

A comment about the case-mix adjusters. Our experience is that we are seeing less than 15 percent -- and we've shared this with staff -- about less than 15 percent of what CMS anticipated and set aside for case-mix adjuster reimbursement.

There was some question as to how we could not know about one of those comorbidities. Some of the comorbidities are not related to their kidney disease or to the treatment of dialysis. Monoclonal Gammopathy, for example, we don't necessarily have in the dialysis medical records, the nephrologists don't necessarily have in their offices, and we often can't get hospital discharge summaries that might have a more inclusive medical history. So some of those are, in fact, unknown to the dialysis facilities

for billing.

Others are known, but let me give you a quick example. Pneumonia is a case-mix adjuster, bacterial pneumonia. CMS requires sputum or an x-ray. Physicians can listen to a lung, hear consolidation, and diagnosis pneumonia. They're betting it's bacterial. They're prescribing an antibiotic. And if it works, it was bacterial pneumonia. We cannot bill it because they saved Medicare money and did not also send a patient to a hospital, which is difficult for this population, to have an x-ray or a sputum done.

So there are real issues with the case-mix adjusters.

MR. HACKBARTH: I'm sorry, but we do need to move ahead.

MS. SMITH: I'm finished, thank you.

MR. MAY: Hi, Don May with the American Hospital Association. Thanks for this time to speak.

I think it's obvious we're disappointed with this recommendation and the direction it's headed. And we're disappointed in some of the analysis that's gone into this. Just over two meetings, we've come to this recommendation

that would produce significant cuts to the outpatient payment system that's already underfunded. And yet, we haven't really looked at how often our hospitals, when they purchase a practice or integrating physicians, really putting them in a hospital setting versus keeping them in a physician's office. What is the appropriate amount? We're going to set it at a physician amount that's 80 percent less than what hospitals are paid and we haven't looked at whether it's even the right amount.

We can tell you it's the wrong amount because it's way off the cost of care in a hospital setting.

We really haven't looked at packaging sufficiently, and that needs to really be analyzed, especially if this goes beyond a discussion of E&M codes. But even with E&M codes, there's much that's packaged that hasn't been discussed.

The impact on weighting, that Herb brought up, has got to be brought up and thought about more clearly. Even if this recommendation goes forward, the impact is going to be more than just rebalancing and revaluing. The weights are now going to be set on the cost of a physician service or the payment for the physician service, not relatives on

hospital costs.

And we also think that this needs to be looked at not as just overall payments to hospitals but as a hospital outpatient department cut. Hospital outpatient department is at 90 percent of cost. This is a 3 percent cut to outpatient payments, taking it down to 87 percent of costs. That's clearly inadequate.

Regardless of what kind of cost-shifting you want to talk about, you can't talk about cost-shifting when the inpatient margin is also negative.

We're also concerned about with a 3 percent average, there are many hospitals that have much more than that. 11 percent of hospitals have more than a 5 percent cut in their outpatient revenue because of this. The teaching hospitals clearly face higher cuts. But public hospitals have a 4.9 percent average cut due to this.

If you look at Grady Memorial in Atlanta, 20 percent cut in their outpatient revenue. It's a $17 million cut, getting at Mitra's concerns, I believe a year -- $17 million to HHC.

We also think Herb's point on the emergency department needs to be looked at.

And if you're going to go with site neutral payment --

MR. HACKBARTH: I'm sorry, Don. I need to interrupt you. I know you know how to reach us.

MR. MAY: I know I do.

[Laughter.]

MR. HACKBARTH: Both the staff and the individual commissioners.

MR. MAY: I apologize. Site neutral, put the money back in the base.

MS. HUANG: Good afternoon, thank you for the opportunity to speak. My name is Xiaoyi Huang. I'm with the National Association of Public Hospitals and Health Systems.

NAPH represents the nation's largest metropolitan area safety net hospitals. These hospitals only account for about 2 percent of the acute care hospitals in the nation but they provide 20 percent of uncompensated care.

NAPH members are vital safety net providers for outpatient services. In 2009 alone, the average hospital for NAPH members provided more than five times the volume of non-emergent outpatient services as other acute care

hospitals in the country.

And not only are hospital services increasingly moving to the outpatient setting as the practice of medicine evolves, producing better results for the patients and lowering overall health care spending, NAPH members in particular have made significant investments to expand their outpatient presence, both in the hospital outpatient services as well as the communities that they serve.

These clinics, such as cancer centers, pain clinics, primary clinics, and sickle cell clinics, are part of our members' effort to deliver integrated, culturally competent care to the most vulnerable of our populations.

Now there are higher costs associated with outpatient care in a hospital versus a free-standing physician office, and much of it is due to the larger regulatory and compliance burdens placed on hospitals. For safety net hospitals these also include unfunded wraparound services such as translators, transportation, patient navigation and social worker. In addition, many of our members' patients in the outpatient setting have multiple chronic illnesses and mental illnesses, which all incur higher costs at the hospital setting.

Now if this recommendation were to move forward, the reductions would discourage safety net hospitals from establishing new and maintaining existing ambulatory care sites at a time when forthcoming coverage expansion will only increase demand for these services.

At this critical juncture, NAPH urges the Commission not to recommend a policy that has the effect of halting progress as hospitals strive to deliver integrated higher quality care. And the reduced revenue to hospitals would further threaten beneficiary access to critical services as hospitals are already operating with negative margins when it comes to Medicare outpatient services.

Now anecdotally, NAPH has heard from several members and the potential impact is astonishing. I'm just going to list a few. University of Washington Medicine --

MR. HACKBARTH: I'm sorry. Time is up and we need to keep moving.

MS. HUANG: Thank you.

MR. HACKBARTH: Thank you very much.

Again, please feel free to use our website.

DR. CONROY: Good morning. My name is Joanne Conroy. I'm Chief Health Care Officer at the Association of

American Medical Colleges, representing 365 teaching hospitals and, I think, close to 139 medical schools now.

We would support a moratorium that would allow a more specific analysis of what are the real drivers of this cost and what may be the unintended consequences of implementing these recommendations. It's obvious to everybody in the room that teaching hospitals are at greatest risk. And for most of us, it would be millions of dollars for every single facility.

But instead of talking about the specific revenue impact, I'd like to talk about access impact because there are three areas that I think are at greatest risk.

Number one, our clinics that serve Medicare patients that cannot afford Part B premiums, of which we have many. There is no access to this care in the community.

The second are those clinics that deal with very complicated patients that require those wrap around services, our diabetes clinics, our Alzheimer's clinics. They cannot be supported on physician payments alone. And again, this is not available in the community.

And finally, our multidisciplinary clinics, which

have really been supported by these payments. Clinics such as our specialty cancer clinics, our pain clinics that focus on medical management. They are important not only to improve a one-stop shop for Medicare patients but they improve satisfaction, they improve access, and they support the very important missions of research and education.

We, of course, would be happy to serve as a resource to the Commission if you want any other information from our members that help you make this very difficult decision.

Thank you.

MS. REEP: Good afternoon, I guess, Kathy Reep with the Florida Hospital Association, representing over 200 hospitals in the state.

I just wanted to make a couple of comments about the site neutral payment and make sure that when we're looking at this, we're looking at it from a perspective of the services being the same, that when you say a mid-level evaluation and management service in a hospital outpatient department, you're talking the same thing as a mid-level evaluation and management service in a physician practice. You aren't.

First of all, the CPT codes have different definitions. There is a defined -- within the CPT manual -- a defined use and what goes into a Level I, II, III, IV, IV evaluation and management service for a physician practice. That is not the case. Although the hospitals use the same evaluation and management codes, the definitions are different. Therefore, you are not looking at a comparable service level being provided.

The hospital is billing for the services it provides. The physician is billing for the services they provide. They are different. They have different definitions.

The other thing that was addressed very briefly was the idea of packaging and bundling under the Outpatient Prospective Payment System. I believe staff made the comment that they did not see very much bundling, particularly in the area of drugs.

I think that if you go back and you look at the claims, those drugs that are under $70 under the hospital outpatient side that are bundled into our evaluation and management service payment are -- under a 250 revenue code would not have a CPT code under revenue code 636. They are

billed in a different format. You might not be identifying them because they aren't distinct, with this is the revenue -- with the CPT code. That 250 revenue code could represent a number of different drugs.

Also, when you look at beneficiary copayment, I think it's important to recognize that drug that is paid separately under the physician fee schedule, the patient has a copay on that drug. They have a copay on the evaluation and management service. They have a copay on the drug.

When you look at the hospital outpatient department, there is a copay on the evaluation and management service, but because the drug is packaged there is no additional copay on the patient.

Thank you.

MR. HACKBARTH: Thank you.

MS. KEEFE: Good afternoon. My name is Alyssa Keefe. I'm with the California Hospital Association. We have about 400 hospitals that we represent in the state of California. And under those, we have about 600 to 800 provider-based clinics.

These clinics are throughout the state and are really an essential part of the safety net for both our

Medicare and our Medi-Cal beneficiaries.

Now despite the discussion today around the table about the national trends in physician employment, it is with limited exception that hospitals and provider-based clinics can employ physicians in the state of California. I think that you know that California is one of the five states, including the large state of Texas, with a strict ban on the corporate practice of medicine and we do not -- as I said -- with limited exception, employ our docs.

We are seeing, though, an increase in the number of visits to both our EDs and our clinics, but it's not due to the trend in physician employment. Due to the ratcheting down of both Medicare and Medicaid patients, we are seeing a significant trend in physicians not accepting these beneficiaries, who will show up in our clinics and in our EDs. However, they will see and are obligated to see these patients in our clinics under the Medicare Conditions of Participation.

Because hospitals do the billing, we do the scheduling for them, and the relationship with our facilities facilitates that specialty care and those wraparound services that my colleagues have discussed, we

can get them to see those patients who can't get that appointment any other day of the week in our clinics.

The proposed recommendation to equalize payment is short-sighted and will only further exasperate the significant access challenges we continue to experience in the state of California.

And if you haven't heard about our access challenges, I'm happy to give you some addition information.

This is not a profit motivated endeavor. It's about providing services to patients that can't seem to get them in other settings.

We urge you not to proceed in adopting this recommendation. Several of the commissioners, and my colleagues that have preceded me, I think have given you much to consider before proceeding.

Thank you.

MR. HACKBARTH: Okay, thank you all.

We will reconvene at 1:40.

[Whereupon, at 12:45 p.m., the meeting was recessed, to reconvene at 1:40 p.m., this same day.]

AFTERNOON SESSION [1:47 p.m.]

MR. HACKBARTH: Okay. It is time to begin our afternoon session, and the first issue is "Assessing Payment Adequacy for Physician and Ambulatory Surgery Center Services."

Cristina.

MS. BOCCUTI: So, in this session, Kevin and I will summarize our analysis of payment adequacy for fee schedule services and Ariel and Dan will do the same for Ambulatory Surgical Centers.

So, first a bit of background of fee schedule services provided by physicians and other health professionals. These services include office visits, surgical procedures, and a broad range of diagnostic and therapeutic services, and these providers can furnish them in all settings, not just physician offices.

In 2010, Medicare spent about 62 billion on fee schedule services. About 900,000 practitioners billed Medicare in 2010. About 571,000 were physicians and the remaining, about 317,000, were other health professionals, such as nurse practitioners, physical therapists, and chiropractors.

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

And finally, while we're on the slide, I want to remind everyone of the Commissions recent -letter to the Congress recommending a path to move forward from the SGR.

A copy of that letter is available on our website, and this work will serve as the Commission's recommendation in the upcoming report for update of the fee schedule payments.

That report will also include the Payment Adequacy Analysis that we're going to present right now.

And so, on this slide -- has an overview of our Payment Adequacy Analysis and the indicators that we used. The first is access.

As you recall, MedPAC sponsors an annual phone survey on this topic. We completed this year's survey a little more than a month ago, so this data is quite current.

We also review other national surveys, both of patients and physicians, and we examine annual growth in volume of services that beneficiaries use.

And in addition to patient access we also examine quality indicators and track the ratio of Medicare-to-

private PPO fees.

And finally, we'll discuss some indirect measures of financial performance for this sector.

So, to review or findings on access to fee schedule services, I'll start with a MedPAC survey, recognizing Matlin Gilman's work on this project.

Just a few details on the survey itself: We survey both Medicare and privately insured individuals 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.

Our 2011 results continued to show that most Medicare beneficiaries are able to get timely appointments and can find a new physician when they need one.

For example, among those needing an appointment for routine care, 74 percent of Medicare beneficiaries and 71 percent of privately insured individuals said that they could do so with no problem.

Appointments for illness or injury were even better for both groups.

These appointment indicators are important,

because most people in these age groups have at least one appointment during the year.

In contrast, needing to find a new physician is fairly uncommon. So, small shares of patient are actually even in the position to be looking for a new physician in the year.

Same slide.

So, for 2011, with our survey, 6 percent of Medicare beneficiaries and 7 percent of privately insured individuals said that they looked for a new primary care physician in the past year.

Needing to look for a new specialist is a little more frequent. 14 percent of Medicare beneficiaries and 16 percent of privately insured patients looked for a new specialist in the past year.

For both Medicare and privately insured people who were seeking a new physician, finding a new primary care physician was more difficult than finding a new specialist.

And although the survey generalizes to all specialists -- and in past meetings, several of you have raised concerns about the ability to find referrals for other specialties, most notably psychiatrists, and we --

this issue did come up in focus groups, and we continue to raise it in our chapter.

So, these pie charts here on this side depict the experience of Medicare beneficiaries looking for new primary care physicians on the top and new specialists on the bottom; so, this is just for Medicare here on this slide.

As I just mentioned, these pies show that looking for a new primary care physician is less common than looking for a new specialist in the year.

Also, you can see from these charts that, while the percentages of beneficiaries experiencing problems is similar -- so, that's the blue and the orange slices in each of these pies -- the likelihood of having no problem when you're looking is much higher among those looking for a new specialist, which is on the bottom pie.

So, now, just looking at primary care and comparing Medicare beneficiaries on top to privately insured individuals on the bottom graph, given the small share of people looking for a new primary care physician, we see that patient experiences fluctuate from year to year, as we go back to 2004.

But for the moment, we're going to focus

specifically on 2011, which would be at the far right side of these graphs. For Medicare beneficiaries, that's the top chart.

The green line shows that 3.6 percent of Medicare beneficiaries said they looked for a new primary care physician and had no problem; that's the green line.

Then, another .7 percent said they looked and had small problems finding one; that's shown with the blue dotted line.

And finally, 1.3 percent said they looked for a new primary care physician and had big problems finding one; and that's shown with the dotted orange line, the more hyphen-like line.

The remaining beneficiaries, of course, did not look for a new primary care physician. And so, they're not depicted on the lines, there.

Moving to the bottom chart, which shows the results for the privately insured, we see that 4.5 percent said they looked for a new primary care physician and had no problems.

Another 1.1 said they had small problems.

And finally, .9 of the privately insured said they

looked for a primary care physician and had big problems.

So, you can see from the charts that there are annual fluctuations in patient experience, due in part to the small numbers of people looking for new doctors. But in general, for both Medicare and the privately insured groups, access to primary care physicians is trending down, which has been concerning the Commission for a number of years.

Our survey continues to find that minorities experience more access problems than Whites in both the Medicare and privately-insured populations.

In particular, for Medicare, we saw that the share of minority beneficiaries reporting problems finding a specialist increased.

Other researchers have documented disparity in access to specialists, but perhaps the Commission might probe further in future surveys to better understand patient experience with this problem. Results could help them form future discussion of potential policy options.

Keep in mind, however, that even though we over-sample minorities in our survey to help with statistical power, fluctuation in this number is expected because of the small share of applicable respondents.

So, switching now to a comparison of rural and urban access, we find that in rural areas, Medicare beneficiaries reported better access than their privately insured counterparts.

And the last bullet on this slide comes for a new question on our survey, asking patients whether they saw a nurse practitioner or a physician assistant for primary care in the past year. In general, the responses among the Medicare and privately insured groups were very similar, with about a third of the respondents in each group reporting that they saw a nurse practitioner or a physician assistant in the past year for some or all of their primary care.

We also found that rural patients were more likely to report seeing a nurse practitioner or a physician assistant more so than their urban counterparts.

For our access analysis, we also look at other national patient surveys, and we do find analogous results to our survey, but in the interest of time, I'm not going to run through this summary slide. Of course, I can answer questions and a little bit more material is included in your mailing materials.

And then, on the next slide, I will do the same here for physician surveys. We know that these are a little bit more dated, but the results are summarized her.

So, Kevin is going to go now, on with the volume analysis.

DR. HAYES: This slide summarizes our with claims data to analyze changes in the volume of fee schedule services for beneficiary. Let me go through the results for the major service categories shown.

From 2009 to 2010, the volume of imaging services decreased by 2.5 percent. The volume of major procedures and tests increased by, respectively, 1.4 percent and 1.6 percent.

Compared to 2009, the volume of procedures other than major procedures was unchanged in 2010.

For evaluation and management services, we could not calculate the 2010 change in the volume of services. Recall that volume growth includes changes in the number of services, but also changes in the intensity of services as measured by the fee schedule's relative value units.

We could not calculate the change in intensity of E&M services because of a payment policy change implemented

in 2010 for one type of E&M, that's consultations. However, we were able to calculate the change in E&M units of service per beneficiary; it was a small decrease of 0.1 percent.

On the decreases in service use in 2010, let me make a few points.

First, such decreases were not limited to Medicare, whether it's national health expenditures data or surveys specific to certain types of services, such as imaging and office visits, the indicators for the general population point in the direction of flat to negative growth in use of services at least in 2010 and perhaps continuing in 2011. The reasons offered vary, but range from a mild flu season in 2010 to higher deductibles and co-pays for the privately insured and to the economic downturn with fewer people covered by employer-sponsored insurance.

Second point: The Commission and others in the policy community have paid particular attention to imaging services. While imaging volume went down by 2.5 percent in 2010, we need to put that decrease in context. Cumulative volume growth during the previous decade was 85 percent.

Third point: There has been much commentary in clinical journals about the necessity of some imaging

services. For example, there is a concern that one unneeded study can start a cascade of other more invasive tests or treatments. Further detail on these points is in the draft chapter.

Let me also mention that a contractor is conducting a study for the Commission that is relevant to these issues. This subject is repeat testing. The list of services considered includes three types of imaging services, echocardiography, imaging stress tests, and chest CT.

In addition showing that there is geographic variation and use of imaging and other diagnostic services, the study is showing that there is often a correlation between how frequently a test is initiated and how frequently it is repeated.

This finding raises questions about necessity and about use of imaging guidelines. It raises further questions about how clinicians spend their time.

Next, Christina will present our work on quality indicators.

MS. BOCCUTI: So, just a quick review here of our assessment of ambulatory care quality and Medicare: Using a

claims-based set of measures, most indicators, specifically 30 out of 38, improved slightly or were stable from 2008 to 2010. Among those that declined, differences were small, and we're talking about zero to about 3 percentage points.

Most indicators that declined were process measures rather than health outcome measures, of course, process measures being rates of selected services received rather than rates of the desired health outcomes.

We found that in the commercial insurance market, NCQA has reported similar declines for measures such as mammography screenings. These declines could be associated with ongoing debate on the recommended frequency of mammography screening.

And for our analysis, we also compare fees in Medicare to those in the private PPO market. We find that the ratio of Medicare-to-private PPO rates continued at 80 percent for 2010, which is the same rate that it was in 2009.

Another item we examine is the rate of practitioners who are classified as participating. That means that the accept the Medicare fee schedule rate as payment in full for the Medicare services that they provide,

and this rate is holding steady at 95 percent.

Keep in mind that participating physicians are not required to accept new Medicare patients. The term "participating" refers to their agreement to accept the Medicare fee schedule rate for all their services. And indeed, we find that about 99 percent of all allowed charges are paid on assignment.

So, Kevin is going to close out the physician and other health professional services analysis with -- well, he'll tell you.

DR. HAYES: With other indicators.

For further perspective on payment adequacy in this sector, remember that fee schedule spending is a function of payment per unit of service and the volume of services. Payment per unit of service has been rising according to payment updates shown here as the yellow line.

Spending per beneficiary is represented by the red line. It includes the updates plus growth and the volume of services per beneficiary.

Equity is another issue that the Commission has been concerned about. Looking at physician compensation data for 2010, we see that, on average, annual compensation

for primary care physicians was $207,000.

By contrast, average annual compensation for physicians in non-surgical procedural specialties was $445,000.

Simulating annual compensation as if all services were paid under Medicare's fee schedule, the disparity remains: $170,000 for primary care, and $398,000 for the non-surgical procedural specialties.

That concludes the part of our presentation on fee schedule services. We will now shift gears with Dan presenting findings on payment adequacy for ASC services.

DR. ZABINSKI: Important facts about ASCs for 2010 include that Medicare payments to ASCs were about $3.4 billion. The number of fee-for-service beneficiaries served in ASCs was 3.3 million and the number of Medicare certified ASCs was 5,316.

In addition, we know that 90 percent of ASCs have some degree of physician ownership, and because of this ownership status, physician owners may furnish more surgical services in ASCs than they would if you they had to furnish those same services in ambulatory surgical -- let me try that again -- for initial services in HOPDs, which is a

sector of the greatest overlap with surgical services with ASCs.

Finally, ASC payment rates are scheduled to receive an update of 1.6 percent in 2012.

In our assessment of payment adequacy, we use the following measures: Beneficiaries' access to ASCs and overall supply of ASCs, ASCs' access to capital, and aggregate Medicare payments to ASCs.

We are unable to use margins or other cost-dependent measures because ASCs do not yet submit cost data to CMS.

In addition, we cannot assess quality of care because ASCs do not yet submit quality data, but they are slated to begin doing so in October 2012.

The measures for payment adequacy for ASCs were generally positive in 2010 as the number for fee-for-service beneficiaries served, the volume of services per fee-for-service beneficiary, and the number of Medicare certified ASCs all increased.

However, this table also indicates that the growth rate of all these measures were lower in 2010 than in previous years.

And to evaluate ASCs' access to capital, we examine the growth in number of ASCs, as capital is needed for new facilities. This analysis indicates that access to capital has been at least adequate, as the number of ASCs grew at an annual rate of 4.6 percent over 2005 through 2009, but the rate of growth has slowed, increasing by 1.9 percent in 2010.

The annual growth has been even slower in the first three quarters of 2011, increasing at an annual rate of 1.3 percent.

The downturn in capital markets in late 2008, the economic downturn that followed, and the slow recovery from that downturn has likely slowed the growth in a number of ASCs, but the economic downturn is unrelated to Medicare payments, so changes to access to capital may not be a good indicator of payment adequacy.

Our data analysis also suggests that ambulatory surgical services may have migrated from HOPDs to ASCs as over the 2005 through 2009 period, the volume of surgical services per fee-for-service beneficiary increase at an average of 6.1 percent per year in ASCs but showed no change in HOPDs.

However, the pace of this migration appears to have slowed or ended in 2010 as growth in ambulatory surgeries was 1 percent in both ASCs and HOPDs.

And to the extent there has been migration of services from HOPDs to ASCs, there are both benefits and cause for concern.

Such a migration can be beneficial because there are efficiencies in ASCs relative to HOPDs for both patients and physicians.

In addition, ASCs have lower payment rates than HOPDs, which can result in lower aggregate payments for Medicare and lower aggregate cost sharing for patients.

However, this is a concern, because most ASCs have some degree of physician ownership, and these physician owners may have an incentive to furnish more surgical services than they would if they had to provide them in HOPDs.

Evidence from recent studies indicates that physicians who own ASCs perform more procedures and that markets that had an ASC introduced had higher growth in colonoscopies and upper GI track endoscopies than markets that did not have an ASC introduced at all.

Consequently, it is plausible that physician ownership of ASCs may have offset some of the reduced spending and cost-sharing that resulted from migration of services from HOPDs to ASCs.

So, in summary, we find that access to ASC services has been increasing. Also, the increase in the number of ASCs suggests that access to capital has been at least adequate.

However, our analysis of payment adequacy of ASCs is limited because we lack cost and quality data that are available in most other sectors.

The Commission has recommended that ASCs submit these data, and CMS has announced that a program for submitting quality data will begin in October 2012, but there is not yet a program for submitting cost data.

So, for the Commission's consideration, the Chairman has the following draft recommendation: The Congress should implement a .5 percent increase in payment rates for ambulatory surgical center services in Calendar Year 2013.

The Congress should also require ambulatory surgical centers to submit cost data.

In regard to the first part of this recommendation, given our findings of payment adequacy and our stated goals, a moderate update is warranted.

However, this is a lower update than the 1 percent that we recommended for the sector that is the closest competitor to ASCs, HOPDs. The purpose is to provide motivation to satisfy the second part of the recommendation, submitting cost data.

Spending implications are that ASCs are poised to receive an update in 2013 equal to the projected CPIU of 2.1 percent, minus the multi-factor productivity of .9 percent for a net update of 1.2 percent. Therefore, this recommendation would produce small budgetary savings.

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

And now, Ariel will discuss a value-based purchasing program for ASCs.

MR. WINTER: Thanks.

I want to first acknowledge the work of John Richardson on this topic and I thank him for his contributions.

As Dan mentioned, CMS has adopted a quality reporting program for ASCs for 2012. ASCs will begin reporting five claims-based measures in October. ASCs that do not report data on these measures will receive a lower update, annual update, in 2014 and thereafter.

However, payments to ASCs will not be affected based on how they perform on these measures. In fact, CMS does not currently have the statutory authority to establish a value-based purchasing program for ASCs that would reward high-performing providers' facilities, and penalize low-performing facilities.

The Commission has outlined several general criteria for performance measures that would apply to any value-based purchasing program. In the interest of time, I'm not going to mention them, but they appear in the slide and they are discussed in your Draft Chapter.

Based on these criteria, a VBPT program for ASCs could include a small set of measures to reduce the burden

on CMS and on ASCs. We discuss several potential measures in more detail in the Draft Chapter.

Most of these potential indicators could focus on outcomes, including patient safety measures, such as patient fall or patient burn, hospital transfer or admission after an ASC procedure, and surgical site infections.

The measures set could also include some process, structural, and patient experience indicators.

Several potential measures are already part of the ASC quality reporting program, but others would need to be developed.

I also want to mention some other key design principles: First, it is important to reward providers who attain certain thresholds of quality as well as lower-performing providers who improve their quality over time.

And second, funding of the pool of value-based purchasing payments should come from existing ASC spending.

So, the Chairman's second draft recommendation reads: "The Congress should direct the Secretary to implement a value-based purchasing program for ASC services no later than 2016."

Given the need to develop additional measures and

gain experience with reporting them, we think that 2016 is a reasonable timeframe to start this program.

Regards to spending implications, we expect this to be budget neutral, however, there are potentially small savings, depending on how the program is designed.

With regards to beneficiary and provider impact, this should increase the quality of care provider to beneficiaries. ASCs will incur some administrative costs to submit the quality data, and high-performing or consistently improving ASCs would receive higher payments than under current law while low-performing ASCs would receive lower payments.

This concludes our presentation. We'd be happy to take any questions.

MR. HACKBARTH: Okay. Thank you.

Before we turn to round one, clarifying questions, I want to say just a little bit more about the relationship between this work and our October letter to Congress on SGR.

Let me start by -- and this is for the benefit of the audience, maybe even more than the Commissioners, but let me just start by reminding people the reasons that we thought it was important for SGR repeal to happen now as

opposed to continuing to defer decision.

First of all was that the cost of repealing SGR, the reported budgetary costs scored by CBO will only increase. That number, in fact, increases at a fairly rapid rate over time.

It was also our assessment that the likelihood that Congress was going to forgive all or substantially all of that budgetary cost was probably declining given the fiscal climate and, frankly, the political climate.

In addition that, we were worried that the potential offsets for that budgetary cost within the Medicare program were being increasingly claimed for other purposes.

For example, the Affordable Care Act includes in excess of $400 billion of Medicare savings over 10 years. They're dedicated to the purpose of expanding insurance coverage

In other pieces of legislation, Medicare savings have been applied to reducing the deficit.

Now, to be clear, both of those are worthy causes. That's not the issue here, but to the extent that Congress decides at some point SGR must be financed out of Medicare,

the fact that Medicare savings are being absorbed and applied to other purposes means that the task of financing SGR repeal out of Medicare gets increasingly difficult over time.

So, we feel this growing sense of urgency about repealing SGR. It's compounded, aggravated by a qualitative sense, I think, shared by many if not all Commissioners that there's a growing sense of fatigue in the physician community with the SGR and the repeated debates over whether SGR ought to be written or not.

And that fatigue -- there's sort of a cumulative effect on attitudes -- physician attitudes towards the Medicare program.

So, our fear, as we discuss the SGR over the course of really this calendar year is that we were getting closer and closer to the point where continuing the SGR could become a destabilizing force in the Medicare Program, and hence the urgency of moving ahead with repeal.

Now, as we talked about that, both within the Commission and with people outside, the ground rule that we established and were urged to establish is that MedPAC is going to repeal -- recommend repeal -- of SGR, we would need

to recommend options for how it might be financed out of the Medicare Program.

To put it bluntly, the Congress isn't interested in hearing from this Commission ideas about increasing taxes on the general population to finance SGR or financing it out of savings from the wind-down of the War in Afghanistan. Those are not issues in which the Medicare Payment Advisory Commission has particular expertise. So, the guidance for us, well, if you feel there's an urgency about repeal, tell us how you would choose to fund it, or options, at least, for funding it out of the Medicare Program, and that is the task that we undertook and we produced our options in our October letter to Congress.

We took pains in that letter, in several places in the letter, to emphasize, however, that this should not be interpreted -- our letter should not be interpreted as necessarily a recommendation that Congress fund it exclusively out of savings in the Medicare Program; rather, our letter was, if Congress chose to fund it out of Medicare, these were the options that we saw for doing so.

At the end of the day, I think there were two key messages that come from that discussion:

One is the urgency that this group, the Commission, feels about repeal of SGR.

The easy path for us, frankly, would have been just to reiterate our longstanding recommendation of repeal of SGR without tackling the very difficult question of how it might be funded out of Medicare, the fact that we did take the difficult step of creating options for funding it out of Medicare -- there's a message there, and it's the urgency that we feel about putting the SGR behind us.

The second message is that I think our letter and the options therein illustrate the difficulty of the task if Congress were to choose to fund SGR repeal solely out of the Medicare Program, and not by using other sources.

And I would say again that that difficulty will only grow over time as the cost of repealing SGR increases over time.

So, that's my effort to try to connect what we did in October with this discussion. I guess as I review the data presented in the last few minutes, if anything, for me personally, and other Commissioners can comment on how they see it, but for me personally, if anything, the data that we just reviewed increases my sense of urgency about repeal of

SGR.

I do think that we need to be careful not to overreact to one year's data, but I think that the significant increase in the number of Medicare beneficiaries reporting a big problem in finding a new primary care physician is a bit worrisome.

And so, well, I will just leave it at that. I think, if anything -- I think these data reinforce the urgency of the message of repeal SGR sooner rather than later.

So, now, let's turn to our Round 1, Clarifying questions, and I can't remember which side we're on.

Karen, clarifying questions? Ron?

DR. CASTELLANOS: On Slide 4, maybe I got the wrong slide -- I'm sorry.

I think I have the wrong -- that was Page 4, in that.

I guess the real question I had for mammogram -- for the clarification issue was -- let me make it a -- number two -- yes, it would be easier.

DR. STUART: Yes, I have a question relating to the comparison of ASCs and hospital outpatient department

payments. And this came up, of course, earlier today in terms of the relationship of fee-for-service and OPDs for E&M visits. I recognize we don't have costs for ASCs, which makes that comparison very different, but we know that there are differences in terms of the amount of time that it takes for surgeries in the two settings and other things that are relayed in the chapter itself.

Do you have a sense of how different the case mix is and whether the case mix differences between these two settings are likely to be the major difference for the -- if you add the cost of care?

DR. HAYES: So, we both -- Commission staff and contractors for the Commission have done work looking at differences in case mix and patient characteristics, and in 2003, we published results of a study which showed that beneficiaries who are treated in ASCs have higher HCC risk scores than HOPD beneficiaries who receive the same procedures. And HSC risk scores, as we talked about earlier, they indicate -- the project the costliness of beneficiaries for a full range of services based on their diagnoses for the prior year. So, it's not, you know, a really precise metric.

But we did contract with RAND to look at specific comorbidities which are likely to be associated with higher costs such as COPD and dementia and diabetes, and they looked at this for two high-volume ASC procedures, colonoscopy and cataract surgery and found they were more prevalent among HOPD beneficiaries than ASC beneficiaries -- patients. So, that was sort of consistent with what we found using HCC risk scores.

The more difficult question, that is, to what extent are these related to -- to what extent do these increase costs in HOPDs? We don't have those data, and I would suspect that the -- you know, GAO looks at ASC cost data from 2004 and found that ASC costs were less than HOPD costs. There is also the data that you cited from the Draft Chapter where RAND found that ASC procedures were faster in ASCs than HOPDs.

So, the question is, how much of that is related to case mix differences versus efficiency, you know, having a customized surgical environment and specialized staff, and we don't have the information to disentangle those two factors, to quantify those two factors.

MR. GEORGE MILLER: Yes, really quickly, please on

Slide 12, the correlation between the frequency a test is initiated, how frequently it is repeated. Do you have that same information broken down by rural and urban -- and this is just anecdotal information: When we would send a patient from a rural area to the urban area, they would just about repeat all the tests. I could never understand why, but they did.

DR. HAYES: We don't have the data in the study, yet, but we could add it. That's a very interesting point.

MR. GEORGE MILLER: Yeah, to see what percentage.

DR. HAYES: Whether it varies, urban versus rural; got it, thank you.

MR. GEORGE MILLER: Thank you.

DR. MARK MILLER: Can I say one thing about that, because we're sort of midstream on this.

We were looking at this geographically -- right? -- and seeing variation in geography. And the one thing I want to just prime you for is that, you know, when you -- and this is an exchange Tom and I had yesterday -- when you look at the differences between urban and rural -- I suspect here, too -- you'll tend to see it dominated by geographic variation rather than urban and rural variation. You know

it will be the fact that it's a different part of the country, you know, Southeast, where you'll have high utilization rates, versus Midwest, Northeast. That'll be, I suspect, the more dominant patter. But I do see what you're saying, but we can look.

MR. GEORGE MILLER: Yes, okay.

DR. HALL: Not really a -- but just to George's point, the repetition of tests is something that is part of the pre-EMR world, I think, of hospitals. It's just too difficult to transport things. I think we're going to see that start to dissipate.

MR. KUHN: Just a quick question in terms of the process CMS goes through in terms of the participating/non-participating physician, do they put out their annual call to physicians whether they want to be a PAR or non-PAR doc?

Is that around the 1st of November and then that goes for about 45 days? I guess my question is, probably, right about now, they're wrapping that up, and when would we know what the PAR rate is going to be for 2012? Any sense of that timing and when that announcement will be?

MS. BOCCUTI: We won't know in time for the Chapter. So, it does happen early in the year, but I don't

think it's going to -- our production.

MR. KUHN: Okay, thank you.

MS. BOCCUTI: We can get it for 20 -- let's see what we produce in the Chapter. I'll talk to you about it. It does happen earlier in the year, and we certainly know that more than we know -- quicker than we know the claims paid on assignment.

MR. KUHN: Yes, and the reason I'm curious is, you know, given the data we've looked at here, the fact that physicians are going through an election process right now, you know, looking down the barrel of a 27 percent cut and not knowing for sure what Congress is going to do, I'm just curious when that information will be available and what we'll know.

MS. BOCCUTI: In the past, there's been some extensions on the deadline because of the uncertainty about the update. And so, that's the -- CMS has allowed an extension for when they have to indicate that they're participating or non-participating.

DR. BERENSON: Yes, when we were talking about the SGR fix that we were proposing, I argued that a lot of specialists really have no choice but to participate in

Medicare because their practice depends on seeing Medicare beneficiaries, but they could treat beneficiaries differently: Faster appointments, not returning phone calls as promptly or something -- do we, in the survey we ask or is there any other source where we can actually capture beneficiary experience with their physicians?

MS. BOCCUTI: Well, it's sort of like, did you get an appointment as soon as you want it -- as soon as you thought was right and as soon as you want it. So, to the extent that what you're saying is they -- if a physician limits the number of patients per week, say, for Medicare, then that would translate potentially to a longer wait time to get your appointment. So, that's one way that our survey looks at appointment time if the physician was having a capacity issue per Medicare, per week, say.

Another -- from the physician perspective, some surveys like HSC has said it's about whether you're accepting all, some, or none patients. So, that way, if practices are limiting the number per month or however they do that, then that captured in there; whereas, the Namsi's it's just any -- it's like, all or none, so...

DR. BERENSON: But I'm not -- I don't think they

can limit the number of Medicare beneficiaries, but I do think sort of the nature of the interaction can change. And so, I mean, I guess I'm asking there are some CAHPS kind of questions or the kinds of questions that Commonwealth uses in their international surveys that I'm wondering, do we have the opportunity to add some of those kinds of questions to the survey?

MS. BOCCUTI: Right. We can ask. We can ask those questions, and we just have to be careful about wording the question, but we'll work on that, and we can --

DR. BERENSON: Yes, and I mean, there are some around, then I'm wondering if --

MS. BOCCUTI: Sure. MCBS asks a lot of questions about their experience during the appointment.

DR. BERENSON: Yeah, that's what I'm getting at.

MS. BOCCUTI: Of course, it's a couple of days later. So, it's some experience questions that we just have to disentangle, whether we're getting this about Medicare payment or access or whether there is satisfaction with the doctor. So, we'll talk about that some more.

DR. BERENSON: Yeah, and I assume the quality measures we're doing all are clinical quality there. There

are not CAHPS kinds of measures at all.

MS. BOCCUTI: CAHPS meaning --

DR. BERENSON: Consume --

MS. BOCCUTI: Right, from the CAHPS survey.

The only ones that we use for that for this analysis are about, did you get an appointment with your specialist when you wanted and routine care appointments.

So, the quality indicators, most of them are process measures or did you get the mammogram screening or did patients -- that it was applicable -- get the screenings. There are claims --

DR. BERENSON: Yes. No, this is from claims data. It's not from survey; right?

MS. BOCCUTI: Right, that's right.

DR. BERENSON: Okay. So, it's mostly their clinical process or limited outcome.

MS. BOCCUTI: Some are outcome but most are process.

DR. BERENSON: Yes, okay. Okay. So, then, I am interested in seeing what we can do to sort of monitor whether the nature of the interaction is changing, not just getting an appointment.

MR. HACKBARTH: Cristina, how frequently does HSD do their all, some, or none new patients question?

MS. BOCCUTI: I think it varies because they have to get the funding for it. So, I'm not sure when the next round is and it's an issue there.

DR. BAICKER: Yeah, I realize that the surveys aren't large enough to do really fine local area slices, but I wondered if in an aggregate way there was any correlation between the places where beneficiaries report problems with access and the places where physicians report that they're not taking new patients or other measures of capacity constraints, like, just physicians per capita or something fairly simple to begin to get some flavor on how much of this might be about supply/demand mismatches versus pricing, et cetera.

MS. BOCCUTI: It's true that, with our survey, we just can't get to the MSA level.

There's a survey that -- well, there are a couple that come to mind, but they're so dated. CMS did a hotspot survey in 2003 and 2004 where they looked at the CAHPS data that -- and picked out the places that had the worst access, but when I say "worst," they were still -- we're talking

about 5 percent of the population saying that they were having problems, but when you rank that up, they were at the worst. And Alaska and some of them -- Denver and other ones -- and then, they went to those areas and asked more.

And then, the findings were that, yes, it was a bit above average, but it still wasn't particularly alarming relative to how many people were having the problems. So, there's been some attempts to go into these areas.

Also, HSC, in the study that we were looking at, they compared payment rates and access rates. So, in places where the differential between Medicare payments and private were larger, the hypothesis would be then the access would be poorer. Well, in fact, they didn't find that. Again, though, this is dated.

I think we mentioned -- I can point that out to you. I still bring that up in the Chapter, and so it's interesting.

DR. BAICKER: Just one more data clarifying question.

DR. MARK MILLER: And on this point -- and Joan's not here -- or Joan has got something else today, we've also -- right?

MS. BOCCUTI: Yes, right, and that's a good point.

DR. MARK MILLER: This is going to be roughly -- you want to pick it up?

MS. BOCCUTI: No, go ahead, Mark.

DR. MARK MILLER: The other thing we have tried to do as we've moved through time is have the beneficiary survey -- and this isn't scientific -- and then go to areas where we hear that there are complaints either from physicians or beneficiaries and try and do focus groups and we have never found quite the relationship that people say. You're going to go there and then it's really going to -- you find some, but again, it's more like the finding from the hotspots thing, even though that's out of date, that was kind of our experience, too.

MS. BOCCUTI: That's true. About four years ago we tried to do that. The problem is, with our focus groups, we're oftentimes trying to accomplish a number of goals from these focus groups. Since we're out there, we want to ask them about lots of things. So, we pick the areas that will help us with the trend that we're following.

And about four or five years ago, we tried to look at some access areas and when to those, but you know, it's

only three.

And this year, I wrote in the Chapter where we went and there were some questions about access.

DR. MARK MILLER: Where we ask questions about access wherever we go, and we've gone to places this year, as well, and I don't think --

MS. BOCCUTI: Dallas and -- yeah.

DR. MARK MILLER: -- we're finding real -- yes, anomalous.

MS. BOCCUTI: Right, we try. The problem is finding that. I think what we found in the focus groups was that people didn't say that they had problems, but they had heard of it more. It seemed that they more said, "Yes, I've heard that there's problems," but didn't actually as often experience the problems themselves.

DR. BAICKER: Yes, so, just one more point of clarification -- how's that? Okay. Because this is going to be really important.

MR. MARK MILLER: Can you sing?

DR. BAICKER: That's no good for anyone.

Another point of clarification: I know you don't have enough people to represent MSAs, but what level of

geographic detail do you know about where people live? Do you know which county they live in or which MSA they live in? So, you could, in theory, if you're not -- even if you can't construct MSA-level measures, you could still correlate the characteristics of the MSA in which people live with their answers to those questions.

MS. BOCCUTI: I see what you're saying. We do have that information, but how much we can correlate is another question, too.

DR. BAICKER: And finding an absence of a relationship would be just as telling as finding a relationship if you had a sample size to believe that you'd found zero as opposed to not being able to find anything.

DR. NAYLOR: So, first, I want to thank you for the responsiveness in looking at other health professionals' contributions to primary care.

And I think the findings that 10 to 11 percent get all primary care from MPs or PAs and a 33 to 36 get all or some is a really important signal as we think about going forward, and it might make sense for us to be thinking about questions that say -- and I totally concur that the findings here suggest that primary care from -- certainly from

physicians -- may be -- that there is a concern and we need to follow up on it. But maybe it also suggests that we can and should look at it in terms of access by physicians and other health professionals, and consistently throughout.

And so, the question I have -- I should put that in the form of a question and say, can you do that?

But the question has to do with really the ambulatory -- ASC recommendations. And I'm assuming the recommendation is for cost data beginning 2013? This is Recommendation 1, so, Slide 24. So, requiring ambulatory care centers to submit cost data in 2013. I just assumed it was.

MR. WINTER: Yes, that's probably the earliest it could happen.

DR. NAYLOR: It's probably the earliest it could happen?

MR. WINTER: Because CMS would have to develop guidelines and set up a cost reporting structure or survey.

DR. NAYLOR: Okay. And so, I was thinking about the alignment with the way the quality measures and the incentives associated with that -- so, as I understand it, the quality measures, if you don't do this by 2014, there'll

be a disincentive in reduction in annual payment.

And I'm wondering, is there a path that we should be thinking about that does that for cost data on the way to 2016 for value-based purchasing.

MR. WINTER: The notion would be to have some kind of penalty for ASCs that don't submit the cost data?

DR. NAYLOR: Right. It comes in earlier on a PEG.

MR. WINTER: I see what you're saying.

So, one of the issues, complications there, is that we propose a couple of different ideas for how CMS could collect cost data. You could think about requiring that every facility, every ASC submits some kind of streamlined cost report.

Another option could be a targeted survey based on a representative sample of ASCs. And so, if you did the survey approach, then ASCs warranted in the sample wouldn't have any obligation. So, they'd be sort of -- they would not be subject to any penalty but the ASCs that were part of this sample would be subject to a penalty. So, it seems sort of inequitable.

But if CMS were to apply to everybody, then they could think about -- you could think about some kind of

penalty, a payment penalty, for ASCs that don't submit the cost information.

DR. NAYLOR: That's what I was -- I was thinking that this was going to be a requirement for all and that, before we waited until 2016, might there be a path that said, "If you don't do it in 2014 or 2015, there might be" -- and aligned with the quality measure.

MR. HACKBARTH: Yes. So, one of the issues around cost data for ASCs has been how can we make that requirement as unburdensome as possible.

And so, as Ariel says, one of the options that we've said CMS could consider would be to use a sample as opposed to an across-the-board requirement.

DR. NAYLOR: So, then, I totally didn't understand this recommendation, because I thought that this was for all, that cost data would -- that we would be requiring --

MR. HACKBARTH: So, what we would do is explain this in the text that we are all on board for, let's do it in a way that is the least burdensome possible, and in years past, we've laid out different approaches that might be considered, and one of those is to just use a sampling approach as opposed to an across-the-board requirement.

On Mary's first point, Mary, are you aware of other research on the question of how many Medicare beneficiaries get their primary care from advanced practice nurses in PAs. And if so, do your numbers reported here jibe with other sources?

DR. NAYLOR: I'm aware of where those data are collected and can -- will connect Cristina. So, I couldn't tell you whether or not they jibe, but I know they are being collected.

MR. BUTLER: An easy one and a not-so-easy one: Page 5, I want to make sure I understand Glenn's point about the dramatic increase in -- difficulty in finding a new primary care physician.

So, I guess the good news is that 5.6 percent of all beneficiaries in a given -- in last year were looking for a new primary care physician; right? And that, by itself, seems so low, if you -- if a physician worked for 40 years, practiced 2.5 percent, would retire every. So, it's like half of that would be, you know -- so, I'm amazed that that few are looking for new primary care -- I guess that's very good news.

I think your point, though, Glenn, is that the 1.3

percent -- in other words, it's like 23 percent of those that are looking are having a big problem and that, in the text, that was like 12 percent last year or something like that. So, that number has almost doubled in one year so that if you -- and you can kind of see it from your graph on the next page, but it doesn't exactly jump out at you that that 1.3 percent was .8 last year.

MR. HACKBARTH: That's correct. So, I think Cristina has quite legitimately framed these slides in a way that illustrates that we're talking about a small portion of the Medicare population seeking a new primary care physician in any given year. So, given that it's only six percent of the sample looking for a new primary care physician when 23 percent of those say they had a big problem finding a new primary care physician, that is only 1.3 percent of the total sample of Medicare beneficiaries.

And so, she's used, as the denominator, the total survey population for all these calculations. And you know, that's a perfectly legitimate way of framing the data.

The other way to look at it is, as you describe that if you compare the 23 percent reporting a big problem this year, it's roughly double the percentage reporting a

big problem in the last two years.

And when I say there's some troubling information to me personally, that's what I'm referring to.

MR. BUTLER: Yeah, it's just like, this morning, we're looking at some small percentage and you say, not a big deal, but if you look at underneath that, sometimes there's more of a story there.

Okay, my more difficult question that I struggle with is that for a number -- I don't know how many -- all the years I've been here, we keep reporting that Medicare payment is about 80 percent of private pay, in terms of physician payment rates, and has been stable.

And we know that Medicare has given virtually no increases. So, that tells me, if I'm reading this right -- and I know a lot of managed care plans tie their rates to some percentage of RBRVS, but that suggests to me that the private side has also been essentially flat.

And so, I'm kind of curious: Given also the work you've been doing on -- and Jeff -- on market power and consolidation, you would think you would see some of that showing up in the physician side, not just in the "health system" side in terms of extracting rates that kind of would

help offset what look like meager rates, anyway. I just wonder if there are any insights or if there is enough volume, that they're not worrying about it, or what are the maybe some of the other reasons why the unit prices have remained flat apparently across both public and private payers.

DR. MARK MILLER: Okay. So, I'm making eye contact with including Carlos all the way in the back there, despite the fact that he doesn't really want to make eye contact.

This is a really good question. I don't think we've thought about it this way. So, unless somebody would like to launch, I think I would like to come back to this.

A couple things that occur to me offhand is the 80 percent can reflect a couple of things, exactly what's going on with a pricing effect, but also if there's any -- however you weight people across private plans. I'm not sure that that's going to have a big effect over time, but you might have something there. So, if people are moving from one plan to another that has a lower rate, you might get some effect there.

The other thing I would say about the

consolidation results is we weren't looking at stuff to date over time. We were just looking from market to market and saying, "Look, in more consolidated markets, there are higher -- appears to be higher prices," but we haven't tracked over time whether they're increasing at lower or higher rates, and that's an interesting question in and of itself, but I really think my sending point is I don't think we've quite looked at it that way, and I think it's a worthwhile question for us to get in deeper, unless somebody else --

MS. BOCCUTI: I don't know. I would only add that it used to be that we had more plan types in the data, but now we've restricted it more to PPOs. So, in order to get a better match and a restriction from the data.

So, it's not so much that there's jumping different plans. It's a PPOs compared to Medicare fees.

DR. BERENSON: Yes, I've wondered the same thing, because I'm sort of doing interviews in this area, and one theory is that those who are gaining market power or getting higher fees, that's being somewhat offset by even more restrictive fee schedules for the price-taking physicians who are the onesies and twosies who -- I mean, I've been

hearing in some cases of fees that not only happen flat but maybe even going down a little bit.

It's just a hypothesis that the variations across physicians are increasing. So, in Miami, health system change findings are that physicians actually accept about 70 percent of the Medicare fee schedule, and there are other places where it's multiple times the Medicare fee schedule.

So, maybe we're seeing an offsetting thing, but that's just the hypothesis.

MR. HACKBARTH: In our data, haven't we found in the past that that ratio, that 80 percent ratio, is different for primary care versus specialty services? And I've heard from people in the insurance world that, even where the Medicare fee schedule is the starting point for negotiations in many markets because of the consolidation of single-specialty groups that then develop lots of market power, they have to pay a bonus conversion factor for specialty services relative to primary care. And my recollection is that Medicare pays a higher percentage on primary care than specialty services. So, it's consistent with that.

MS. BOCCUTI: On average, right. That number is

averaged across all geographic areas and all services. So, there's variation by area and by service type and your recollection is correct.

DR. BERENSON: And one very quick thing, what we saw in a couple of markets that the fee schedules weren't going up but that the groups with market power were getting incentive payments to accomplish certain things. So, it was not in the fee schedule but it was payments going because the plan had committed to a uniform fee schedule but it had an ability to move some many.

MR. BUTLER: So, I started this. I'd add additional comments, but you folks have all violated Round 1 so severely that I won't do that.

MR. HACKBARTH: That's not -- you tricked us.

[Laughter.]

DR. CHERNEW: Yes. So, I have a question about Table 4.1 which that's the one where you show the issue about the 23 percent going up from 12 percent that Peter was asking about. Yes --

MR. HACKBARTH: It's in the paper, yes.

DR. CHERNEW: My question is, you do statistical tests relative to private, but you don't really look at the

trend over time. So, my first question is, the table only goes back to 2008, but are there surveys that go back before 2008 and they're just --

MS. BOCCUTI: We go back to '04. We do test -- let's see.

DR. CHERNEW: The tests that I saw were versus private and then, whether, within groups, there were differences, but not over time.

And the reason I say that is, versus -- 23 versus 12 looks really big, but 23 versus 18, which is the first number in your table isn't quite as alarming. So, I'm not sure if I --

MS. BOCCUTI: We can do that over time, recognize that, when you go back to '04, in '04, we were only surveying, I want to say, 2,000 -- I have the numbers. We've increased the size of --

DR. CHERNEW: Right, from 3,000 to 4,000.

MS. BOCCUTI: -- our sample every year. So, when you go back to a smaller size, you're not going to get the significance, when you compare those years. But we can do a little bit more of that by year.

DR. CHERNEW: Right. And also, when you look at

private, there are some big swings in the private side in that table, too.

So, my only comment is -- and I don't want anything in this question to at all imply that I am not concerned about the potential for access problems, because I think that is crucially important as we move into a more fiscally constrained world. I think it's amongst the most important things we can do.

That said, I do think it's important because you're looking at a relatively small sample and then a relatively small percentage of that sample that, over time, you can get swings that don't imply broad trends.

If we had seen the, say, one -- the number for 2008 was, like, 8, and then it went to 12, and then it went to 23, that might be a trend. But if you look across the numbers that are presented, it's not quite as clear to me that there's a trend.

Now, it is true that 2009 was also 12 percent. So, there's some work that needs to be done, but it's not clear to me that what's driving this is anything that we're particularly talking about. And then, although it may be, it needs to be considered seriously.

MR. HACKBARTH: Just -- I'm sorry, Karen -- but just to be clear on the physician payment side, what I'm proposing we do is simply reiterate our October letter as our view in the physician payment system.

DR. BORMAN: Yes, I'm generally in support of the recommendations here. I think, as mentioned earlier, when we had the conversation about E&M and HOPDs that this whole issue of how we pay across for similar services across sectors is important.

I think we've done a nice job of getting to some -- - maybe a more full explanation than we had previously about some of the advantages of ASCs and some of the good things that they do. And so, I'm pleased to see that, as well.

I thank staff for making a very nice piece about that.

MR. GRADISON: I support the recommendations.

DR. CASTELLANOS: I'm sorry about earlier.

Two things: I support the recommendation.

I have a little concern about the survey and I do think it is important to look at the surveys. I agree they bounce from year to year, but that's the only indication we have now for access.

And Mike, I agree with you: That's the big elephant in the room, I think, as we go forward.

I am concerned about primary care, but I'm also somewhat concerned about specialties. On Slide 4, one of the clarifying questions is, why is 6 percent of the primary care beneficiaries having problems looking for a primary care, but it's also 14 percent of the Medicare beneficiaries? Why is there a difference between...

MS. BOCCUTI: It's not having -- oh, Glenn, did you?

MR. HACKBARTH: No.

MS. BOCCUTI: It's not having problems here. This is just the number that -- the share that are looking.

DR. CASTELLANOS: Okay. Why is there a difference in the number?

MS. BOCCUTI: Well, that's a good question. It really seems that people are -- it's more frequent that you be looking for a specialist because you have a new problem or a new ailment or a reason.

So, the frequency that people are in the position to be looking for a new doctor is higher when it's a specialist, in which case -- and I think as Karen has

brought up before, too, it could be a more short-term experience, too. Whereas, your primary care physician, to be in the position to look for a new one is less common because once somebody has that physician they often stay with that physician for many years, if not for their -- for the physician's career.

DR. CASTELLANOS: Thank you.

On the survey problems, again, we don't have the chart, but the chart that was given out to us in the material that was sent on Page 12, I'm a little concerned, and I think George may want to comment on this -- it always seems that the minorities have a higher problem than -- you know, and is it because of the location? Is it because of comorbidities? Is it because -- I think that needs to be looked at. The minority population, really, whether it's primary care or specialty really seems to make a big difference.

MS. BOCCUTI: Yes, we certainly picked that up and discuss it a bit in the Chapter and note that we could think about doing more work in our survey to look at this more deeply and think about what issues are at play here, and that could inform future policy options.

DR. CASTELLANOS: Now, another question: I go back to this morning where we were trying to compare one to another, and as we progressed down this course of site of service, it's probably going to be easier comparing oranges to oranges rather than oranges to apples.

Now, I notice the ASC really depends -- CMS depends on the CPI. Is there any indication or suggestion that maybe we get an ASC market basket so when we get to compare ASCs and hospitals, we have similar data together?

MR. HACKBARTH: Two years ago, three years ago, we recommended -- we had a formal recommendation that market basked, specific day SEs or an alternative to the CPI be developed for ASCs.

The CPI, by its nature, is a more volatile nature because it has energy prices and food prices and all those things in it, in addition to the fact that it doesn't adequately capture costs that are specific to ASC operations.

And I don't remember the history of why Congress wrote CPI in the statute, but it seemed to us two or three years ago that it was inappropriate adjustor and we made a recommendation that a better one be developed.

Do you want to fill in some more?

MR. WINTER: Yes, and CMS, every year, they get comments from the ASC community that the CPI is not an adequate measure of input cost, and we have said similar things and the recommendation was that CMS should collect cost data from ASCs, both to help us assess payment adequacy but also to assess whether an existing market basket is an appropriate proxy, or whether an ASC-specific market basket should be developed.

And when CMS gets these comments every year that the CPS is not an effective measure, they have not responded to them directly until this past year -- until this year, actually, last month -- when they said, "Well, we're going to think about whether -- an alternative market basket would be better -- an ASC-specific market basket would be better and, as part of that, we may need to collect cost data."

And so, for the first time, they seem sort of open to the idea that we may need to get ASC cost data so we can develop a more appropriate ASC market basket.

MR. HACKBARTH: So, is the decision about the ASC market basket a regulatory decision or is that in statute?

MR. WINTER: It's regulatory.

According to how CMS interprets the statute, they have discretion.

DR. CASTELLANOS: And just a comment to Bob's comment about Miami, only because I live in that state, you're right, but I think it's more related to the volume or number of doctors there.

By that I mean they can afford to give 6 percent of Medicare and the doctors will go for it. I know they did the same for us as specialty, but what we did to combat that, we joined a large group and said -- and maybe it's not right say in the public, but we were able to say to them as a large group that, I'm sorry, but we're not going to accept that.

So, I think a lot of it is due to the large volume --

DR. BERENSON: And that was the point I was making: The physicians are becoming haves and have-nots based on whether they're willing to become a larger group, and it's just sort of too bad that, by default, we're probably going to see the elimination of the small practice, whether it's a good thing or a bad thing, simply because of the ability of plans to squeeze on the fee schedules.

DR. STUART: I'll just note that if you're from Florida it's easier to make oranges to oranges comparisons than if you're in New York which, by definition is going to be apples to oranges.

I've done a lot of work on MCBS, and one of the key variables that we've looked at is whether a Medicare beneficiary says they have a usual source of care, and it turns out that 95 percent of beneficiaries say they have a usual source of care, but then when you look at what they say their usual source of care is, primary care physicians don't rank up there very high. Well, they rank up high, but not anywhere near as high as I think we're assuming here.

And I'm just wondering whether this is part of your survey, is if you read this -- if you read these results really quickly and see that only 5 percent of beneficiaries are looking for new primary care physicians, that doesn't necessarily imply that 95 percent have a primary care physician.

So, do you ask whether they have --

MS. BOCCUTI: We do ask, but I don't have that number in my head. I could look it up while you're talking and then -- but we do ask, do you -- we started asking, do

you have a primary care physician, and that might necessarily comport with the six points, but I bet it's very close.

MR. STUART: Okay. Because we've found that some say, well, the emergency room is my usual source of care.

MR. GEORGE MILLER: Yes. I can support the recommendation.

And just to Ron's point, and I appreciate him bringing it up, but we consistently see a patter about disparities in all sectors that we cover, and I would be pleased if we work on -- and I think we talked about it one time -- working on a comprehensive policy to address across the continuum dealing with disparities in health care, and not only racial minorities, but I think I've been quoted before talking about Appalachian Whites, and where there are disparities and where it's appropriate for this Committee to address that issue, but if we don't, we're going to have an underlying problem about access to care, which is part of our responsibility to deal with access to care.

And this Chapter pointed out -- and I really appreciate getting the information pointed out, but I would certainly like to see us move definitively to start

addressing disparities, and I think you said, the first year I was on the Commission that the Congressman from Cleveland who died gave me a little bit of a hard time about that issue and about how we address that.

So, remembering that statement, we need to really focus in and address that and maybe even convene a panel to talk about that issue across the board, across the spectrum.

MR. HACKBARTH: And recommendations?

MR. GEORGE MILLER: I support them.

MR. HACKBARTH: And Bruce, I forgot to ask you.

DR. STUART: Yes, I support the recommendations.

MS. UCCELLO: I support the recommendations.

Bruce was kind of going along the lines that I was going to ask about, about the flip side of not looking doesn't mean having. But I'm also wondering, as you're looking up these numbers, whether there are differences in having a PCP among minorities, and whether that could contribute to more difficult finding specialists, if they don't have someone kind of helping them find a specialist.

MS. BOCCUTI: That's an interesting question and we can look at that. I hadn't thought about that, getting the referral, you know, so that -- but I would say that the

numbers for Medicare, we ask -- we ask, do you have a primary care, and we also ask, were you looking for one. So, they're not the same.

And but still, do you have one? 94 percent of Medicare said, 5 percent said no, and so the others are, I don't -- the 1 percent there is I don't know.

And for private, we've got 93 percent said yes and 7 said no.

So, it's very close to those numbers, but it's a different question.

DR. STUART: If you could check those against MCBS for some other years, I think you'll find that when you ask a -- if you ask a beneficiary whether they have a primary care physician, they may not be thinking of primary care physician the way we're thinking about primary care physicians. That would be one of my concerns here.

DR. HALL: I agree and I'm in favor.

MR. KUHN: Thanks. This is another good discussion.

Well, it's pretty clear to me that the program doesn't work if the key doesn't fit the lock, and whether when we're looking at this new data, whether it's a

statistical wobble where Mike I think was kind of talking a little bit about whether it's a trend. You know, whatever it is, this new information I think is disturbing. I think I agree with Glenn, that it adds to the urgency. And I think it's another bad omen that the door is closing on more and more Medicare beneficiaries' access to care.

So, in that regard, I definitely want to reassociate myself with our recommendation on SGR. We need to get rid of it, and support the ASC recommendations, too.

DR. BERENSON: Yes, I support the recommendations.

Just a comment about the very interesting volume information showing a moderation and even a reduction in volume of imaging. Actually, this follows a few-year trend of slowing and now declining.

I sort of going in would have that Medicare beneficiaries, 90 percent of whom have supplemental insurance are sort of immune from general economic forces that seem to be in play since the recession; that is, I think, one of the explanations for decreasing volume on the private side for elective stuff, but it's happening in Medicare also, and I think it would be nice if we understood why that is.

You know, it may well be that the physician community is partly responsible for this. I'd also make the other point that the deficit reduction act in 2006 took a major whack out of a lot of advanced imaging prices, and we did not see what at least some think is the common response, a behavioral response to increased volume in response. I think there's a natural experiment here which we maybe could understand a little more about. What we've seen is a reduction in price and a reduction in the rate of increase in volume for services and, to me, that's an encouraging development.

So, I would -- I think it would be nice if we could understand that a little bit more.

DR. BAICKER: I support the recommendations.

DR. NAYLOR: I generally support the recommendations. The question about cost, I'm still not clear on so I'll just -- I'll process that because I don't know whether or not you're talking about all -- all sites requiring, et cetera, but I know that that will unfold over the next couple of weeks.

Certainly reinforce the concerns about access, and can I make a comment on the quality issues, because as you

read the headlines in the report, it looks like quality has improved or many measures remain stable.

And I think that is true in reading your review of the quality indicators that are process-related, but on the MACIE measures I think it might be helpful to -- I don't know if "stable" is the right word. I would say one got worse -- two of these measures declined in terms of potentially avoidable hospitalizations, and three for which there were no changes, and I think that that's in different kind of -- I mean, we want to get better in potentially avoidable hospitalizations. So, I think framing this in a way in which the data suggests, really, in five out of six, there were no changes or things got worse, is a different kind of message as it relates to potentially avoidable hospitalization. So...

MS. BOCCUTI: Well, the reason we say "no change" is that it's not statistically significantly different.

So, saying that they --

DR. NAYLOR: No change is good. The word you use is "stable," and it implies to me --

MS. BOCCUTI: So, you prefer the wording "no change" rather than stable. Gotcha.

DR. NAYLOR: Your headline is they got better or remained stable, and if I were to just close the book, it would look like that's a really --

MS. BOCCUTI: I understand.

MR. BUTLER: First, to reinforce Bob's -- not only in the utilization here but utilization on hospital -- utilization most across -- we should celebrate a little bit. I sense some moderation that is a very positive thing that we see.

Also would congratulate the second paragraph under the SGR in the Chapter I think really says well what we're trying to do and what we were not trying to do and why it's maybe a little different from what we've done before. So, if you have opportunities to, whenever it is, to kind of explain what it is we're trying to do, I think those were really good words.

MR. HACKBARTH: So, Peter, where are you --

MR. BUTLER: On Page 3, the second paragraph, it says what we recommended under the SGR system and why we did it and what the context was for those recommendations.

I just thought it was -- I know everybody here really wanted that well stated when we came in and I think

that really does capture it very well.

MR. HACKBARTH: Good.

MR. BUTLER: I think on -- I was going to mention disparities for a little different reason. I think we've made a lot of progress, and I was kind of -- our strategy was not to have a separate chapter but to have it recognized everywhere. We're doing that and we maybe need to diagnose a little bit more, but I'm trying to think ahead to what's the treatment, how do you use the payment system -- we'll learn more about the reasons, but we really -- it's not too early to kind of think and anticipate, is there some way we would likely have payment recommendations that could help address some of the disparities that we're seeing, and particularly in the physician access arena. And I don't have an answer, but I think we need to kind of move beyond just documenting and moving ahead and thinking or anticipating what some of those models might be.

MR. HACKBARTH: I agree with that. We need to think about whether there are opportunities where we can use payment as a tool to redress disparities.

Of course, we also looked at the reworking of the QIO program as potentially a way to address disparities at

least indirectly by focusing on the improvement of low-performing hospitals and other institutions, and the data suggests that one reason -- potentially many reasons for disparities is that minority populations are more likely to get their care from low-performing institutions. So, if we can elevate the performance of those institutions, that can help. It's not that that's the only thing, but it's potentially one step.

MR. BUTLER: So, my last point is, now that we've got the minorities, licked --

[Laughter.]

MR. BUTLER: -- I wanted to move on to the disabled population. And I don't mean that lightly but in the last several years we've built a new ambulatory facility and we're about to open a new hospital facility where we had extensive engagement with the disabled community in terms of guiding us on not just meeting ADA compliancy but in doing that you learn a lot about how they access care or not, not just from a facility standpoint, but all of these other specialty services.

And given that Medicare covers the disabled, we don't really have any data on them as a group and their

utilization and access to physicians, and I'm wondering whether that is -- again, this is one of those, well, how many are there? Well, there's a bunch, and we really have not looked through their lens in saying, "Are they getting to primary care physicians? Are they getting to specialists?" And because there are numerous barriers that they face that are kind of unique to being disabled.

So, I think we owe it to ourselves to think about how to poll them in this process.

DR. DEAN: I support the recommendations. I don't really have anything to add, except that the drop-off in the imaging is really striking. Do we have any way of determining what influenced that? Like Bob said, it would seem like it's sort of counterintuitive almost, but...

DR. HAYES: We have some limited evidence that the same kind of thing, in addition to what Bob said -- we do have some evidence that the same kind of thing has occurred for the general population; so, this would be outside of Medicare.

And the one concern expressed for that population, for the population generally, is just patient concerns about radiation exposure.

DR. DEAN: It has gotten a lot more attention in the last year or so.

MS. BEHROOZI: Thanks, all of you. This is a lot of stuff. I'm trying to juggle it all over -- just a couple of points.

On the data and the directionality and things like that and looking actually at the ratio disparities page, looking at the percentage of people who are looking makes the differences bigger, as has been expressed.

And I mean, I'm struck by the people who had no problem finding a physician, who were looking for one, and primary care physician among African-Americans, it was -- or minorities, sorry -- it was 57 percent. So, it was really almost half of the people had some problem finding a physician, a primary care physician, which seems like it should be of concern; right?

And then, among specialists, minorities had significantly more problems than among White people, which might say something about specialists' ability to choose where to practice and whom to see and what kind of coverage to accept.

So, to your point, Glenn, to looking elsewhere,

you know, among the other recommendations we make, I remember talking about the issue when it came to medical education and support for loan forgiveness or whatever programs that would help place medical graduates in places where they might not otherwise choose to go and that way sort of open up access.

So, that particular dimension of the difficulty in finding physicians, you know, I think is important. But yes, just generally, again, the directionality of all Medicare beneficiaries having no problem finding a primary care physician is consistently -- I mean, it's not all one direction but it's lower in this past year than it's been at all before.

So, whether that's, you know, partly perception and people saying, "Well, I think I'm going to have a problem or, you know, yeah, I found one, but it wasn't as easy as it was before," it's all tied to the anxiety, I think, around the SGR. So, totally support restating that.

On the ASCs, you know, I get -- sure, why not say half a point, but that -- I'm not sure it's compelled by the fact that there's still increasing utilization, there are more ASCs, there are more beneficiaries, there's more

volume, even in a year of decline in other areas. I mean, we saw an absolute decline in inpatient, whatever, stuff like that. So, I'm not going to be the holdout and object to half-a-percent, but I don't know that it's justified in the way that we often see it, and getting the cost data obviously is critical and I don't know that the sort of tradeoff, the half-a-percent for saying, now, we really need cost data. I don't know if it's working, but certainly the cost data I absolutely support.

And the quality payment program, the value-based purchasing program, do we have to wait until 2016?

MR. WINTER: So, it's actually a pretty aggressive timeline if you think about it, and I'll walk you through it.

So, they're going to start collecting data, these claims-based measures, four outcomes measures, one process measure, starting next year, fourth quarter next year, which would give them, in 2013 and 2014, CMS would have two full years of data to establish a base period and a performance period so they can measure improvement in those scores for ASCs.

And then, in 2015, they could calculate the

scores, give that information -- give ASCs a chance to appeal those scores if they think there are errors, and announce what the change in ASC payments will be in 2016.

So, what we're saying is the payments will start to change in 2016, but we recognize there's a need to gain experience reporting on these measures and calculating scores, and there are also some other measures we think should be developed, like surgical site infection rates and patient experience, and that's going to take some time, as well.

So, we wanted to build in some time for that, but we're open to your input, obviously.

MS. BEHROOZI: Whatever works.

DR. CHERNEW: I support the recommendation.

MR. ARMSTRONG: Yes, I have a little more to add.

Just I would, for the record, like to affirm that I really agree with Peter on a couple of points he made here, and that, in particular --

[Laughter.]

MR. ARMSTRONG: -- in contrast to our last subject, but in particular, I think it's a big deal for us to be moving in the direction of resubmitting our

recommendation around the SGR fix and the rates that are part of that.

And Glenn, you said this earlier, I think some of this data suggests that even more important as we go forward that we get this thing fixed and we get some of those rates in place.

I feel the same way about supporting the recommendations you've laid out for the ASCs, as well.

MR. HACKBARTH: Thank you very much. Well done.

Next is skilled nursing facility services.

[Pause.]

DR. CARTER: Before I get started, I wanted to follow up on a few questions from the discussion in November.

Bob had asked about the discharge destination of SNF patients, and the key ones are: about 34 percent of beneficiaries go home, about 27 percent are rehospitalized, and 19 percent are still a patient but no longer in a Medicare-covered stay.

Ron had asked about the variation in SNF use across markets, and I looked at the per capita bed availability of IRF in long-term care beds in markets, and

then in comparison looked at the variation in medically complex days and in high-intensity therapy days, and I did not find a strong relationship between the availability of those beds in markets and the site visit use.

Mary had asked about the all-cause rehospitalization rates, and work by Vincent Mor and colleagues found it was 24 percent.

Bill, you asked about the Medicaid shares of days in high- and low-margin SNFs, and those shares are similar. They're 64 and 62 percent, and I included that in the table, so I thank you for that suggestion.

For a road map I'll start with a thumbnail sketch of the industry and then present information related to the update. Then I'll provide a summary of Medicaid trends that we're required to report and end with material on a rehospitalization policy. And I wanted to thank Kelly Miller for helping me with this chapter.

A quick thumbnail sketch of the industry. There are just over 15,000 providers. About 1.7 million beneficiaries -- that's about 4 percent -- use SNF services. Program spending in 2010 was almost $28 billion, and Medicare makes up about 12 percent days but 23 percent of

revenues.

We'll be using the update framework to assess the adequacy of Medicare's payments. I'm going to go quickly through this material, but there is more detail in the chapter, and I can certainly answer your questions.

Access appears stable for beneficiaries. Supply has been steady, with 50 fewer providers in 2011 compared to 2010. There was no change in bed days and occupancy rates. Covered days and admissions decreased slightly between 2009 and 2010 but remain above levels in 2006. And the small decline is consistent with lower hospitalization use, which is required for Medicare coverage.

What we see in quality is very slight improvement since 2000 and virtually no improvement between the last two years of available data, and that's 2008 and 2009. There was really almost no change in our two measures, and those are risk-adjusted rates of community discharge and rehospitalization for five potentially avoidable conditions. And since 2000, there has been a slight improvement in community discharge rates, but almost no change in rehospitalization rates.

Access to capital was adequate this year, and

lending and borrowing is expected to be slow in 2012, particularly in the first half of the year, reflecting uncertainties about state and Medicare policies. Because Medicare is a preferred payer, lenders and the industry use Medicare shares to gauge the financial health of the industry.

Comparing payments and costs, the aggregate Medicare margin for free-standing SNFs was 18.5 percent in 2010. The rural and urban average margins were similar. But as you'll notice, there's quite a bit of variation, ranging from 9 percent to almost 27 percent, looking at the 25th and 75th percentiles, and variation by ownership. Some of this variation is due to the mix of cases that facilities treat. Facilities that provided a lot of intensive therapy had the highest margins. The variation also reflects cost differences. Nonprofit facilities have costs per day that are 7 percent higher than for-profit facilities. Hospital-based facilities had very low margins, a negative 67 percent, but they contribute to the hospitals' bottom line. Hospitals with SNFs had lower inpatient costs per day and higher inpatient margins than hospitals that did not have SNFs.

We use consistent performance over three years to define a group of SNFs that are relatively efficient, that is, they're both low cost and high quality. And the methodology is similar to what Jeff described this morning and is included in the paper. And I have about 10 percent of free-standing SNFs that qualify, and it's over 900. Compared to other SNFs, relatively efficient SNFs had costs that were 10 percent lower, community discharge rates that were 38 percent higher, and rehospitalization rates that were 17 percent lower.

For the rural report, we examined Medicare margins by the degree of rural-ness and found that margins were above 15 percent for each of the four rural categories. We did not find a strong relationship between volume and Medicare margin.

To project margins for 2012, on the revenue side we assumed market basket updates with the forecast error correction made in 2011, and the update in 2012 that was net of productivity. We also included the overpayments in 2011 and the reductions in 2012.

On the cost side, we assumed costs grew at a mix of both the most recent cost growth and market baskets for

2011 and 2012. We did not model any behavioral responses. And we project the average margin to be 14.6 percent in 2012. The margin goes down a little bit relative to 2010 because costs are estimated to increase faster than the market basket in 2011. And on the revenue side, while the reduction in payments taken in 2012 was done to restore revenues back to the levels prior to the overpayment and then adjusted for the market basket, there was also the forecast error correction and the productivity adjustments that lowered the payment updates.

There has been much made of the 11-percent cut in payments and its anticipated impact on the industry, and I wanted to make two points about this reduction. First, it was a correction to re-establish budget neutrality with the adoption of the new case mix groups in 2011. The rates that are in place for 2012 are higher than the rates that were in place in 2010. Second, the reduction was taken from a level that included the overpayments that we now estimate resulted in an average margin of 24 percent in 2011.

There are several facts that support the need to rebase payments. First, aggregate margins for SNFs have been above 10 percent since 2000. The variation in Medicare

margins are not explained by differences in patient mix. And cost differences are unrelated to wage levels, case mix, or beneficiary demographics.

We also find that relatively efficient SNFs show that it is possible to have both low costs and high quality. There is some evidence that MA payments are considerably lower than fee-for-service payments. MA payments ranged from 12 to 68 percent lower than fee-for-service payments for five SNF companies.

And, finally, the industry has responded to the level of payments in two ways. First, cost growth has outpaced the market basket every year since 2001. Second, revenues grew, even when rates were lowered in 2010. These factors show that the PPS has exerted too little fiscal pressure on providers.

While rebasing Medicare payments will establish a more appropriate level of payments, it will not correct the known shortcomings of the PPS that are partly responsible for the wide variations in financial performance. Our recommendation back in 2008 to revise the PPS would establish a separate component for nontherapy ancillary services, base therapy payments on patient care needs not

service provision, and add an outlier policy. Without raising total spending, the design would shift payments from SNFs with high shares of intensive therapy to those with high shares of medically complex days.

We've estimated the distributional impacts of a revised PPS. Payments would decrease 10 percent for SNFs that furnish a lot of intensive therapy and would increase 17 percent for SNFs that treat a high share of medically complex patients. And there is a table in the chapter that has a lot more categories and examples.

Based on the mix of cases, payments would shift from free-standing SNFs to hospital-based facilities and from for-profit to nonprofit SNFs. However, the impacts on individual facilities could vary considerably from these averages based on their mix of patients and current practice patterns. For example, we estimate that payments would increase by at least 10 percent for three-quarters of hospital-based facilities, but there is a handful of hospital-based facilities that would see their payments decline by that much.

This leads us to the Chairman's draft recommendation, and it reads: The Congress should eliminate

the market basket and direct the Secretary to revise the prospective payment system for skilled nursing facilities for 2013. Rebasing should begin in 2014, with an initial reduction of 4 percent and subsequent reductions over an appropriate transition until Medicare payments are better aligned with provider costs.

Rebasing and revising are both necessary to reform the SNF PPS -- the first to bring payments closer to costs and the second corrects the distortions in the PPS. The recommendation proposes to start with a zero update while revising the PPS, and then begin to lower payments in steps, which would allow CMS and the Commission to assess each year how the industry is faring and if beneficiaries have access to care.

This recommendation would decrease program spending relative to current law. For beneficiaries, fairer payments across all types of care may result in providers being more likely to admit and treat beneficiaries with complex care needs. Provider payments will be lower, but the differences in Medicare margins across facilities will be smaller. Impacts on individual providers will be a function of their mix of patients and their current practice

patterns. The recommendation would not eliminate all of the differences in Medicare margins between providers due to their large cost differences.

As required by PPACA, we examine Medicaid trends in spending, utilization, and financial performance for nursing homes. We reported on these trends last year as well. On this slide, you can see that there are about 15,000 facilities that participated in Medicaid, and that was a small decrease from 2010. Between 2009 and 2010, the number of days increased almost 3 percent. Spending decreased slightly to just under $50 billion. The aggregate non-Medicare margin was negative 1.2 percent, while the total margin -- which includes all sources of revenue -- was 3.6 percent, and that was a slight increase from 2009.

A key argument the industry makes against rebasing is that facilities lose money on Medicaid and need the high payments from Medicare to be viable. Using Medicare payments to subsidize Medicaid is poor policy for a number of reasons. Using Medicare days to direct subsidies to Medicaid ends up helping facilities with lots of Medicare patients, and those are exactly the facilities that need the help the least. It also doesn't discriminate between states

with relatively high and low payments. In the paper is a comparison of the average Medicaid payments per day for 40 states, and they vary twofold. Medicare's high payments subsidize facilities even in states with relatively high Medicaid rates. If Medicare raises or maintain its high rates, it could encourage states to freeze or lower their rates. And, finally, payroll taxes that finance the trust fund subsidize the low payments from other payers. If Congress wishes to help nursing facilities with high Medicaid mix, then a separately financed and targeted program should be established to do this.

Last month we started to talk about a policy to discourage unnecessary rehospitalizations that can result in poor quality and are costly. A rehospitalization policy for SNFs would align hospital and SNF policies to improve the transitions between the two settings. While some factors that influence rehospitalization are within a provider's control -- such as their staffing and medication management -- others are not -- such as the worsening of a patient's condition. We do not want to create a policy that discourages SNFs from hospitalizing patients whose conditions require hospital care. Given this complexity, it

is important that a rehospitalization policy accommodate the variation across patients and circumstances, but still encourages operators to improve the care they furnish.

On this slide you can see the variation in rehospitalization rates for the five potentially avoidable conditions. Between the 25th and 75th percentile there is a 60-percent variation. And the median rate for hospital-based facilities was almost half that of free-standing SNFs, in part because hospital-based facilities have ready access to ancillary services without needing to readmit the patient. On average, for-profit SNFs had rates that were 25 percent higher than those for nonprofits. We found that some facilities have consistently high and low risk-adjusted rates. For example, over 900 facilities were in the worst quartile three years in a row.

A hospitalization policy needs to consider the definition of the measure, the time period, and the penalty. Regarding the definition, a measure could consider only select conditions or include all causes. The argument for targeted conditions is it gives providers more direction on which practices to focus on. It may be more actionable than a broad measure. On the other hand, an all-cause measure

would reflect the belief that all rehospitalizations should be avoided. The five potentially avoidable conditions we track account for about three-quarters of SNF readmissions and could represent a good place to start since a risk adjustment method is already available. Over time, if desirable, the measure could be expanded to include all causes.

Turning to the time period, one that covers the entire SNF stay ensures that a facility is at risk for all of the care it furnishes to a beneficiary and does not encourage SNFs to delay rehospitalizations until after the measure's time period is over. In the future, the measure could be expanded to include a period of time after discharge from the SNF to encourage facilities to ensure effective care transitions for patients. A phased approach would allow CMS to move forward with a policy and begin to lower rates while a risk-adjusted measure that includes a window after discharge is developed. CMS will need to monitor provider behavior after the measurement window to ensure that providers are not shifting care to beyond window.

And, finally, the penalty would apply to

facilities with high rates of readmissions, not individual stays. Evaluating rates has the key advantage of not assuming that a specific rehospitalization was avoidable. Looking at rates over multiple years would avoid penalizing providers for one bad year, and this leads us to the Chairman's draft recommendation, which reads:

The Congress should direct the Secretary to reduce payments to skilled nursing facilities with relatively high risk-adjusted rehospitalization rates for their Medicare-covered SNF stays.

In terms of implications, it would lower spending relative to current law. Fewer beneficiaries would be hospitalized unnecessarily, and more beneficiaries would receive better transition care. The policy would prompt facilities to focus on care processes and better communication that lower rehospitalizations. Payments to providers with patterns of high rates would be lower.

And with that, I'll put up summaries of the draft recommendations and look forward to your discussion.

MR. HACKBARTH: Thank you, Carol. Clarifying questions?

MR. ARMSTRONG: Yes, just a brief comment. You

may have said this. My apologies if you did already. These recommendations are consistent with and were included in our SGR proposal. Is that correct? Or are these --

DR. CARTER: They are consistent with that, yes.

MR. ARMSTRONG: They're consistent with that, okay.

MR. BUTLER: The most stunning data to me was the rehospitalization rates and the hospital-based SNFs, how dramatically lower they were. And there's a lot of money there, if that's what they're doing. My speculation might be, well, the physicians are -- sometimes rehospitalization is just access to certain physicians and other things that aren't in a free-standing home, and so you don't have to move them from their bed because they can kind of get that assessment done because it's sitting in the same building. Other than that, do you have any speculation as to why they're a lot lower?

DR. CARTER: We do think that the availability of ancillary services -- so you don't really -- you know, you can get some of the ancillary things like an X-ray or whatever that wouldn't be available at a SNF. You can do that without having to put the patient back in the hospital.

So we have read that the availability of ancillary services helps with that.

DR. MARK MILLER: There's also some research we did years ago with some people from North Carolina, and when you look at characteristics of patients kind of underneath the case mix level -- I'll take a minute while you get your next thing all teed up there. When you look at characteristics underneath the case mix level, there's clear selection of sort of who stays in the hospital and who the hospital sorts out to a free-standing SNF.

DR. NAYLOR: Can I just add to that? I think when you use "ancillary," I think you also mentioned in your report the availability -- direct access to physicians, nurses, more immediate access to those.

DR. CARTER: I thought that was the point Peter was making.

DR. NAYLOR: Great. Thanks. So my question is, just to sort out on the readmission recommendation, so hospitals now have a penalty or will be having a penalty in the first 30 days for readmissions that occur immediately post-discharge. And this recommendation would be let's extend this to skilled nursing facilities for the 100 days?

And what if they go from a skilled nursing facility or hospital SNF, which they often do, to post-acute home care? So I'm just trying to figure out how application of this would -- it seems to me that there is potential for overlapping financial disincentives.

DR. CARTER: The reason to have 100 days is that is the benefits, so somebody can stay in a SNF, and so we do want a facility to be at risk for the entire stay that they're responsible for. So that does mean that the time period would differ from the hospital measure.

Now, on the other hand, the hospital measure is after discharge, whereas at this point what we've been talking about -- and I lay out -- you could start with a facility -- a SNF measure and then begin to include something after discharge, and like the hospital penalty, you could include a similar 30-day window after discharge, and that would make those measures parallel, if you will.

Does that help?

DR. NAYLOR: [off microphone] Yes, thank you.

MR. HACKBARTH: So, Mary, I'm not sure I understand.

DR. NAYLOR: What I was thinking about is Mr.

Smith is hospitalized for three days, and the hospital is accountable for the first 30 days. But he could be spending that first 30 days in a skilled nursing facility and then spending the next 30 from 100, whatever. So, you know, is the hospital accountable and -- so if he's rehospitalized at day 28 in the skilled nursing facility --

MR. HACKBARTH: They could be both be accountable.

DR. NAYLOR: Exactly.

MR. HACKBARTH: And, in fact, that's the goal.

DR. NAYLOR: That's the goal. And then that's what I was trying to ask. And then if he goes to a home health agency, because often they don't -- the average length of stay in these facilities is not 100 days. It's much closer to 30 days. So if he goes to a skilled home health agency as part of this, are we thinking of extending -- because they are accountable for readmissions, not in a payment way. So that's what I just wanted to make sure.

MR. HACKBARTH: Yes. On the SNF piece, if I understand Carol correctly, the first step would be just to hold them accountable during the SNF stay and not a post-discharge window.

DR. NAYLOR: Right. Okay. So --

DR. CARTER: And part of that is we don't have a risk adjustment method for the period after discharge, and I would assume those factors might be a little bit different.

DR. BAICKER: I actually had a question right along those lines. You talked a little bit about how it would be more difficult to incorporate a window post-discharge, but it seems like that might be very important in terms of really wanting to avoid the incentive to send somebody out the door quick before they have to go to the hospital. And so I wondered how much harder you thought it would be to start with the future step on page 22 of having a 30-day post-discharge window from the get-go if we're worried about the incentives around that margin. Is it really impractical to implement that right away?

DR. CARTER: You know, I don't feel like I know enough about what you would want to do on the risk adjustment side for the post-discharge, and so that's my only hesitation there. But I agree with you in concept. I think you do want to include them.

DR. BAICKER: And why is it so much harder than -- given that it's the same person that you had the information on while they're in the SNF, what are the barriers or the

challenges to --

DR. MARK MILLER: Carol, correct, as I go, I would characterize our position here just a little bit differently. What we have developed on-the-shelf and been reporting to the Commission for however many years is a risk-adjusted stay measure. And so I think part of our reasoning is you could start to move forward with that now, and I think what Carol was trying to lay out is that may be incomplete. There's more of a picture here that needs to be developed. And I think -- this is just in her typical style, being cautions and saying we should start to work down onto the window following it. We may encounter some issues there, but off the cuff, we have a measure that's stay related; you could start with that and look at 30 days, and if it seemed to behave, then maybe you're there. So I think the way I would characterize it is the reason we're starting with the stays, we have that on the shelf right now, risk-adjusted, et cetera.

DR. CARTER: Right. And I wouldn't characterize my hesitancy as it's harder to do the risk adjustment. We just haven't done it.

DR. MARK MILLER: That's what I'm trying to say.

DR. CARTER: Right.

DR. BAICKER: So then that just raises the question of which is the greater danger: having a risk adjuster that you're using in the 30 days after that was designed for the stay and may not be quite right for the 30 days after versus creating a cliff where hands off at 30 days, and those are competing dangers? And I don't have a sense for which one is worse and that we don't want the perfect to be the enemy of the good, but I don't know which of these two is "gooder."

MR. KUHN: Carol, on page 8 you had some of characteristics of relatively efficient providers, and you may have stated this, but I might have missed it. But when you talk about the characteristics of these in terms of the types of facilities, free-standing, hospital --

DR. CARTER: This whole analysis was done on free-standings. There are about a little over 900 facilities. They're a little slightly more likely to be rural and nonprofit, but they're very similar to what the mix is in the industry, and those points are in the paper.

MR. KUHN: Thank you.

DR. CARTER: Sure.

DR. HALL: I think I know the answer to this, but let me just quickly make sure. On Table 10 on page 36 in the material we were sent, there were the variations in risk-adjusted rehospitalizations. I guess my question is: How about that subset of patients who either are duals or who really have used up Medicare eligibility? Is there a marked variation in rehospitalizations in people who don't have, shall we say, a relatively better payment status?

DR. CARTER: I'm pretty sure I have those numbers back in my office, because we typically look at things by duals and minority and very old, and I can get those to you.

DR. HALL: A lot of this behavior of who gets the patient between the hospital and the SNF obviously has a lot to do with who gets paid and who doesn't and the negotiation that goes back and forth. I think that might be useful to take a look at.

MS. UCCELLO: I have two questions and a suggestion.

The first question is: Can you remind me of the rules regarding how rehospitalization, whether and how that restarts the clock?

DR. CARTER: So when a beneficiary has to have a

hospital -- to qualify for Medicare coverage, you have to have been hospitalized within 30 days and hospitalized for 3 days. And then when you're rehospitalized, in our measure the rehospitalization starts a new stay, and so when we're looking at rehospitalization rates, we haven't looked to sort of compare their coverage. We're just looking, okay, if they were rehospitalized, then that counts as one. And if a patient ends up being rehospitalized three times, then that person counts three times in our measure.

MS. UCCELLO: Okay. But how does that affect the co-pays? Does that start again from there is no co-pay or do they keep -- if they go back to the SNF, does it start back on day 20 or something?

DR. MARK MILLER: Let me ask you this, Cori. Is your question -- forget the readmission measure. You're asking what's the mechanics if somebody -- how long do they have to be in the SNF before they can be readmitted to the hospital and restart their stay?

MS. UCCELLO: [off microphone]. Yes, the SNF stay.

DR. MARK MILLER: The SNF stay, right. Did you catch that?

DR. CARTER: I will have to look at that [off microphone]. I think it's the same stay, but I'll have to check. And so the co-pay starts at day 21. I'll have to check on that. What were you going to say?

DR. MARK MILLER: We'll clearly come back on this.

DR. CARTER: Yes. I'm sorry. I should have it.

DR. MARK MILLER: No, it's all right. And, actually, I know you know this. We went through this about three years ago, and we'll just dig it back out, and we'll answer your question directly.

DR. STUART: I think it relates to spell of illness, which --

DR. MARK MILLER: That's what I think, too.

DR. STUART: Which requires that you be out of both institutions for 30 days. I think.

DR. CARTER: It's 90 days without an interrupted institutional stay.

DR. MARK MILLER: Something like that, right, but we'll work this up and bring it back.

MS. UCCELLO: And the reason I'm asking is partly, you know, what are the financial incentives to the SNF for the rehospitalization. One of them is if you can get some

of these high-cost people back out and have a hospital pay. But is there anything else associated --

DR. CARTER: Well, I think there are two things. One is, you know, if somebody starts to be high cost or you can't manage them on the weekend because of the kind of staffing you have on the weekends, you might rehospitalize. But for -- so there's always that financial incentive, and then, of course, for the long stays, you might want to try to requalify somebody for --

MS. UCCELLO: Right, and so I guess my question is: Do those people -- for that to be an incentive, do they have to have already gone beyond 100 days or something? It might not even matter. But in any case, my second question is whether or not we've gotten any input from MACPAC on our rebasing recommendation.

MR. HACKBARTH: So I did talk to Diane Rowland, the Chairperson at MACPAC, and they have no work in progress related to really any rate issues. They aren't currently doing payment adequacy work for Medicaid, and so they do not have anything directly relevant to this.

MS. UCCELLO: And my suggestion is to kind of better emphasize this issue regarding how it doesn't -- how

Medicare doesn't really subsidize Medicaid in a sense. It might be helpful to show a distribution of the composition of Medicare and Medicaid patients. If that composition is constant across facilities, then that subsidizing issue actually has more play. If there's a bigger distribution, then that makes our case more, I think.

MR. HACKBARTH: Are you referring to variation in the proportion of Medicare versus Medicaid?

MS. UCCELLO: Yes.

MR. HACKBARTH: Across institutions.

DR. CARTER: Well, just off the top of my head, I know that -- because I just looked at this for Bill -- the share of Medicaid in high and low margins, so those are quartiles, was very similar, 62 and 64 percent. But hospital-based and free-standing have really different mixes of Medicare, and so I'll get back to you on what that distribution looks like.

MR. GEORGE MILLER: Yes, it was mentioned in the presentation the recommendations would create winners and losers. And I'm just wondering in my mind, especially for the losers, there's a lot of variation in the margins as we discussed, and then I don't know if we've done an

assessment, who would be the losers, where they'd be located, and what impact they would have on particularly vulnerable populations, patients at risk, and dual eligibles, as Bill mentioned, if we had that granular data yet. And my question is: Do we have that data where the winners and the -- where the losers would be? I'm not concerned about the winners, but where the losers would be? And would we adversely affect access if we move forward with the recommendations?

DR. CARTER: I think in general the winners and losers have more to do with their kind of mix of therapy and medical complexity and not dual eligibility and minority shares, but I can get back to you on that. The short story is facilities that had a lot of high therapy that appears to be unrelated to patient care needs have the largest declines, and --

MR. GEORGE MILLER: Okay. That part I don't have any problem with. I understand that part of it. I'm just wondering with the variability in the margins, are we also going to, unfortunately, wash out a couple of providers or providers just fall out of the wash that would deny access to care or could have a negative impact on access to care.

DR. CARTER: Right. I will reiterate something that I said in my presentation, which is there are large cost differences cross facilities, and you can't -- these redesigns don't address that. So to the extent that you're seeing an overlap with high-cost facilities and sort of who they treat in terms of demographics, you can't solve all the problems, and some of it is really a cost structure problem.

MR. GEORGE MILLER: Okay.

DR. STUART: I have a quick question, Carol, and I may just have missed this. I think when you were talking about relatively efficient facilities, you indicated that there was no correlation between low cost and low wages. Did you check whether there was a correlation between low cost and staffing ratios?

DR. CARTER: I haven't looked at staffing ratios.

DR. STUART: I think staffing ratios would probably be even more important than wages in this respect because -- and there would, I think, be a clear correlation with potential quality as far as that. So I would suggest that.

The second question is actually for Glenn, and that is, the second recommendation is very general, and I'm

wondering why it's not more specific. And I know you indicated that there's kind of a tradeoff between being specific with respect to the type of rehospitalization as opposed to all rehospitalization. But it also strikes me that, you know, we've done all this work on these five conditions, and why wouldn't we start there by saying let's have a program that penalizes rehospitalization. We'll start with these five where we've done work and then consider something beyond that, so at least it gives the Secretary and Congress -- because this is going to go to them -- the basis for that recommendation, some of the statistical basis for that.

MR. HACKBARTH: Carol, would you just put up recommendation two slide? And so you would add to that language staying focused on the five conditions and make it more specific in that way?

DR. STUART: That would be my recommendation.

DR. MARK MILLER: My line of reasoning -- and, you know, some of it is also to feel out what the Commission wanted, because remember we come in with a draft and say is this where we're going, you know, that type of thing.

But the other thing just to keep in mind is how

much of this do you want written into law versus how much you want to leave to the Secretary to make adjustments. We've had the industry in in various incarnations on all of these recommendations, as you might imagine, and there was actually some discussion on this. I'm not going to characterize this as an industry position, but some people who said, you know, this isn't something that we would necessarily oppose, but we might do it differently. There were questions about all cause versus potentially preventable, what the window would look like. And so I think, you know, we were trying to gauge your interest and also leave some openness to if there are other ideas here and then your points, we could put in the text and say here's where you could start, and then if the industry has -- okay?

MR. HACKBARTH: Does that work?

DR. STUART: I think that was the thinking.

MR. HACKBARTH: I think that's a good point. This requires a statutory change, and I guess I would be a little uneasy about specifying five conditions in the statute because that means when you have data to go to ten, you have to go back and get a new piece of legislation. So we can

address that in the text.

MR. GRADISON: Looking forward to tomorrow's discussion of hospice, do you have any data with regard to the proportion of Medicare-paid days in skilled nursing facilities that are paid for, in effect, by the hospice program? I'm particularly interested in trends over time.

DR. CARTER: I haven't looked at that, but I'm wondering if Kim has. I'll get back to you on that.

MR. GRADISON: For tomorrow. Thanks.

DR. BORMAN: Carol, I know you didn't cover it, but I wonder if you could help me refresh on something. When a Medicare SNF patient is rehospitalized, what is any requirement and/or option for that bed to be retained available for that patient when that patient is discharged from the hospital?

DR. CARTER: Medicare doesn't have a bed-hold policy. Many states do for Medicaid, so there's -- they don't reserve the bed or anything like that.

DR. BORMAN: Because it does occur to me that if a patient were rehospitalized for the preventable conditions, the ability to get that money might also be something that might be appropriate to consider withholding or modifying,

that if they went back for a preventable readmission, you shouldn't be able to get additional revenue during the time that they're readmitted. But if there's not a uniform policy, then it becomes a moot point.

MR. HACKBARTH: Round two.

MR. ARMSTRONG: So I would start by saying I support the direction we are heading, particularly with recommendation 1. And, number two, I'm a little uncomfortable with the vagueness of it, but I thought that conversation was actually helpful to me.

The margins in this sector are spectacular. I think we're overpaying for the services that we're getting. I think that what we're talking about here is payment policy that's consistent with positions we've analyzed and taken in the past.

I would just say that this is frustrating because it's a little like Whack-a-Mole. You know, we're trying to deal with an issue here, and when we do, it pops up somewhere else so long as we're dealing with payment policy in the confines of these silos that really are completely indifferent to and inconsistent with how patient care actually takes place.

I know I'm articulating a frustration that I share with many of you, but I hope -- I mean, we have to do this, I recognize, but I hope this reminds us of the importance of looking at bundled payments, looking at how Medicare Advantage plans manage transitions and rehospitalization issues and so forth, which I know is on our agenda going forward.

DR. CHERNEW: Yes, I support the recommendations as well, and, you know, as we go through a sequence of long-term care-type providers, this issue of the fragmentation just becomes so salient that it's challenging. So I'll just say that I agree completely with your discussion of the Medicaid subsidy portion, but I would like to point out that I think in the hospital side we may be doing something almost in the opposite where our margins are low but the overall margins are okay, so we sort of glide a little bit on the fact that some other payers might be more generous.

I don't know if that's exactly analogous.

MR. HACKBARTH: In fact. that is not the reason for the hospital recommendation. The hospital recommendation is focused on the lower cost of the efficient providers, and so we're trying to make recommendations

consistent with the cost of efficient providers. It's not based on having higher all-payer margins.

DR. CHERNEW: Okay. And my general point was going to be that I think margins is just a very difficult way to try and manage what the right payment should be because margins can go up or down in sort of complicated accounting ways that we don't really know. So I don't like margins as being our fundamental goal. And, in fact, in the recommendation where it says we should start cutting until payments sort of hit costs, I'm not tremendously comfortable as that being the ideal sort of target as to where to do. But, you know, I think the recommendation is in the right direction, so I'm fine to support it in that regard. And I think the extent to which we can make a sequence of recommendations that span all of the providers we're about to discuss to sort of push us to a more efficient way of dealing with this population, which clearly has a lot of issues, the better. But given these recommendations, the bottom line is I'm supportive of them.

MR. HACKBARTH: Carol, would you put up recommendation one for a second? So what we say here is that the first step of this rebasing would be the 4-percent

reduction in 2014, and then we make a reference to possible additional reductions so that payments are better aligned with provider costs.

So what I imagine, just to amplify on what that last passage means, is that over the course of the next cycle, what we would do is look at various ways that we might target what the ultimate rebasing might be. So one way to think about that is that the ultimate target ought to bring payments in line with average costs.

Another way to think about it is that we ought to bring payments in line with the cost of efficient providers of skilled nursing services. And then within that category, you know, you can imagine a distribution of costs within the efficient provider category, and you could set it at the 50th percentile of the efficient category or the 75th. So there's more work to be done about what the ultimate destination is here, but I want to be clear that the message isn't, oh, just overall average cost is what we ought to target.

DR. CHERNEW: So I guess that might suggest a little thinking about the wording, but a third option might be we'll keep cutting until the various analyses that Carol

does, or whatever, suggest that we should cut no more. And that might end up getting us close to the efficient provider, and it might end up getting us close to where we find there's a big access problem or some other issue. But I think the point is -- and the reason why I think I'm generally supportive is I think there's reasonable evidence that there's some room to cut without unduly bad reductions in access or quality, and so this is sort of a directional thing. I think the recommendation as worded is probably a little more strongly than you just said, possible future reductions, I think it does a little more strongly about how to do that, but I would emphasize that as recommendations go, I'm basically fine with the spirit of this, and maybe some tweaking would make me prefer it, but, you know.

MR. HACKBARTH: You don't need to do it right now, but if you would just take a minute and jot down what that preferred language would be, that would be helpful.

MS. BEHROOZI: I also support recommendation one. Directionally, I guess, as Scott says, I'll think about, you know, the exact number or whatever, and year and stuff like that. But one thing I want to say is that, you know, I have a lot of sympathy for the providers who are really trying to

make a go of it with not even a high Medicaid share. The average Medicare share is a minority of the business. And, you know, I recently had some interaction with some nursing home operators who, you know, talked about their rates being different by four- or five-fold between Medicare and Medicaid. So I don't know, I mean, we've got some evidence that Medicare is overpaying, but, you know, Medicaid is really vastly underpaying, and that's in a state that, you know, has a pretty robust Medicaid program.

So I take very seriously, Glenn, your arguments, which, you know, you make very compellingly, about why Medicare should not be used as a subsidy for Medicaid. And I think actually we need to be more mindful of that in these times of austerity budgets among the states where some states are making choices about their Medicaid budgets that should not be borne by other states -- I mean, people, you know, the citizens of other states that are dealing with their own problems. And as you said, if there needs to be resolution to that problem, it shouldn't be through Medicare, through this, you know, one piece of a much larger financing puzzle for nursing homes.

MR. HACKBARTH: To me, that's sort of a new

element of our discussion of this issue which has been with us for a long time now. So what we have said in the past is simply it doesn't make sense to us to cross-subsidize Medicaid with Medicare. And what I envision this time, as Carol said in her presentation, is we may go an extra step and say, you know, if Congress were to decide that it wants to do something to offset what it considers to be unduly low Medicaid payment rates to nursing homes, there are better alternatives for doing that than using a high payment rate under Medicare, ways that the money could be much more effectively targeted and achieve its true objective. And so what I envision is, you know, we'd have a little discussion of that in the chapter to sort of point a direction.

Now, some of those mechanisms would be through Medicaid, and I don't think it's appropriate for the Medicare Payment Advisory Commission to usurp the territory of MACPAC in that regard. But there are also ways that they could do it through Medicare but preferably not using payroll tax funds to do it.

DR. CARTER: I just wanted to add one thing, which is one of the key reasons why Medicare and Medicaid payment rates are different is because the patients are different,

and if you compare the nursing case mix index and the therapy case mix index for those patients, Medicare and Medicaid, those patients are very different. And for the same acuity, Medicare payments for the acuity of the Medicaid patient would be $212, and the average acuity Medicare patient gets paid $380.

So they're just different, and we hear these comparisons all the time, that the nursing home rates for Medicaid are really low. They are. But their patients are also really different.

MS. BEHROOZI: The Medicaid payment would still be significantly below the $212, or whatever it was, but -- and they should be different patients. But then there is also the question of to what extent there's a financial incentive for a nursing home with dual-eligible beneficiaries to rehospitalize to start the Medicare payment stream over again. And I just wanted to note in connection with the second recommendation about a rehospitalization policy, the -- I just underlined and drew exclamation points next to your line in the paper that said SNFs with the worst rehospitalization rates had much higher Medicare margins than SNFs with the lowest rates, and it looks like their

margins are a third higher than those with the lowest rate of rehospitalizations.

So, you know, is it stinting on care? Is it revenue maximization? What's the relationship there? The SNFs with the highest rates treated more dual-eligible beneficiaries, you also said. So it's not all bad, it's not all wrong. There are co-morbidities and case mix risk adjustment issues with dual-eligible beneficiaries or beneficiaries who came out of nursing homes rather than out of -- I mean, who started in nursing homes rather than came out of the community into the SNF.

But, anyway, so the vagueness of the language, you know, I understand why the recommendation might be vague, but I do think it's important to be pretty robust and pointed in the chapter about what we think is going on, the best we can tell from the data, and that includes the five conditions, that includes these financial incentive issues, I think. Anyway, I support it.

DR. DEAN: Yes, I support the recommendations. I had some of the same concerns about number two. I think it's really important to try to get the incentives for hospitals and SNFs in sync so that you don't have the

nursing home trying to admit the patient and the hospital saying, no, don't do that. I mean, I can envision all kinds of problems there.

But also, in looking back at the mailing material -- and I think we've talked about it before, that there are apparently increasing problems with a declining number of SNFs that are willing to take the medically complex patients, and I think we need to be cautious about the wording of number two because, obviously, that group of patients are the ones that would be, I would assume, most likely to have to be rehospitalized.

So I think it would be useful -- and I'm not exactly sure what the right terms are -- to put potentially avoidable hospitalization -- I mean, we use that in some of the other things, or something so that we didn't increase the disincentive that SNFs have to take patients that have multiple problems and that are likely to need this rehospitalization. But I basically support it.

MR. BUTLER: So the first comment on the efficient provider concept, I think we do need to recognize there's still an art to all this in the end. Otherwise, if we really applied efficient provider for Medicare across all

these sectors, we would not be -- the recommendations that we're voting on would look different than they are now. So that's a fact. And we do worry about the implication -- well, enough said on that one.

I do support the recommendations. I do like the flexibility in recommendation two at this point in time. And then I would just make one further comment on hospital-based SNFs, which I had kind of written off as unworkable and not advocated for -- and never advocated for more unless you could demonstrate from a patient mix, so I'm pleased to see that, you know, there could be a potential bump-up.

I think the hospitals that have stayed in this business haven't done the calculation, gee, if I have this unit, I have this length of stay shorter, I get these savings, therefore I'll do it. I think the analysis has been more if I have a unit that I'm not using the payment exceeds the variable costs of running that unit, they'll stay in the business. That's probably the more common calculation. And I think what you'll find in a positive way -- and you don't hear any hospitals that have gone out of this business get back in it. We should say something. It's not quite enticing as it may sound. It sounds like if

you're in it, you're going to make more. Not really. At least that's not the calculation people are making.

However, if they're 27 percent higher, if you have this kind of pickup on the rehospitalization rate, if you're able to coordinate care better and, for that matter, an additional move outside of a facility for an elderly patient is extraordinarily disruptive, plus organizations like us, we have electronic records, for example, now in our rehab unit as well as our inpatient, you get a much greater ability to potentially coordinate care. Suddenly it's got my attention. I'm saying, Hmm, now this could really be better care with an electronic record, don't need to make money off of the unit in the way we account for it. But when you couple it with the rehospitalization, now you're talking a different patient model that could really benefit the patient.

MR. HACKBARTH: What I hear you saying, Peter, is that if a provider goes to an ACO model, then the hospital might --

MR. BUTLER: Now you've got something much more robust to offer --

MR. HACKBARTH: -- think very differently about a

hospital-based SNF.

MR. BUTLER: Or even with what's being proposed here, this is directionally, I think, a very, very good way to go.

DR. NAYLOR: So I support redistributing payment to assure that the medically complex people and dual eligibles get really the best care. And I also support the notion of, wherever possible, alignment of these policies. So I'm going to just give you brief reactions because I know time is running.

On the issue of rebasing, as I look at it, I actually had a different reaction to the percent change in payments which would tremendously create an incentive for hospital-based efforts. And I was thinking about this more in alignment with our principles of trying to promote use of sites of care that are less costly, that are more efficient, that are still very, very effective. And hospital-based facilities right now have two times the cost because they have higher-quality staff, as I understood it, than post-acute -- or skilled nursing facilities and nursing homes. And we don't also know fully the real costs, meaning how many of the patients from the hospital-based SNFs go to home

health as a result.

So I think that -- I really appreciate, Carol, your work has laid out the complexity of these issues around an episode of care issue. So I would be concerned that we would unintentionally move care to higher-cost environments.

But I think, on the other hand, the lessons learned from what we are seeing from hospitals is how important high-quality staff is -- nursing homes, physicians --

MR. HACKBARTH: So just for clarification, which policy are you worried might encourage use of higher-cost --

DR. NAYLOR: Well, rebasing, I'm looking at Slide 15, where hospital-based -- the percent change in payments to hospital-based facilities would increase by 27 percent.

MR. HACKBARTH: This isn't rebasing. Page --

DR. NAYLOR: Oh, the budget neutral. I'm sorry. Okay.

MR. HACKBARTH: This is the new case mix system.

DR. NAYLOR: Got it. All right. So that -- all right. But, anyway, in this general sense of incentives, I think that we want to make sure that our incentives don't accomplish something we -- we would want -- so help me here.

Rebasing is redistributing.

MR. HACKBARTH: Slide 15 is a budget-neutral redistribution so that our payment system better reflects the actual costs of different types of patients.

DR. NAYLOR: Okay. So this in no way would create any incentives for hospitals to grow. That's what I thought I heard Peter saying.

MR. HACKBARTH: Only as an incidental effect that, you know, Peter -- another hospital executive might say, oh, our payments went up 27 percent and that affects my analysis of whether to use this potential set of beds for a SNF versus some other purpose.

DR. BAICKER: But the reason that they're going up is because they're already treating more expensive patients, but not getting --

DR. NAYLOR: Not getting paid for it.

MR. HACKBARTH: Not getting paid fairly for them. Right.

DR. NAYLOR: Got it. This is the redistribution. But could it have that unintended consequence -- I don't know -- of creating incentives? But, anyway, all right, let me --

DR. MARK MILLER: And just remember, at this point the hospital-based, because of the type of patient that they take, our concern is under the current PPS, they are faring poorly because of the payment system, and so this is in a sense trying to level --

DR. NAYLOR: So this is the reason they have decided to move out --

DR. MARK MILLER: -- the playing field across different players, but on the basis of the patients that they take. And this is just a vocabulary point, in case it helps you guys. Internally, we call this PPS reform. Then there's rebasing. Then there's the rehospitalization. That's the vocabulary we throw around in the office, if that will help you keep the three things straight.

DR. NAYLOR: Okay. I'm totally not -- but, no, that's great. That's exactly what it says, so I should -- and on rehospitalization, my only concern about the policy or recommendation as written is limiting it to the stay because these units exist in most -- 90 percent of them in nursing homes, and you can see incentives to change Mr. Smith from a skilled nursing facility bed to a long-term care bed. Anyway, it concerns me that this is not really

taking a look at what's happening in the short term and not creating incentives to move people from short stays to long stays.

MR. HACKBARTH: So it sounds like your concern is related to Kate's comment in round one that if the program is just limited to the SNF stay, then you might create an undesirable incentive to say, oh, I want them out of the SNF before the rehospitalization occurs, I'll put them someplace else.

DR. NAYLOR: That's exactly right.

DR. BAICKER: So I am very supportive of the direction of these, and I am in general in favor of bigger bundles that go over longer time periods and incorporate more different kinds of care. But I understand that you don't want the risk adjusters to be off so that people then avoid complicated patients, and seeing a little more evidence on which of those is the greater risk would be helpful in refining the details. But I think the direction is great.

DR. BERENSON: I support recommendation one strongly, and I won't go into that any more.

On recommendation two -- that's the one that's up

there -- this hasn't been brought up. I think this is right, so I would want to check it out. It seems to me that the kind of inventories the SNF would need to do to reduce rehospitalizations, I assume heavy reliance on advanced practice nurses and developing an Evercare kind of apparatus and other things, would also have a -- would be the same kind of thing they would do to reduce hospitalizations of duals who were in a nursing home, not in a SNF stay, so that we actually -- this is, I think, especially important to start here to incentivize the nursing homes to take this on and will help policies around the duals. So I think there's a very positive spillover effect here.

I guess if I had to say anything of concern, it's why would we necessarily want to limit it to those with relatively high-risk rehospitalization rates rather than moving quickly to having this be a policy for all SNF stays. I actually think the hospital readmissions policy errs by only focusing on hospitals that have excess readmissions rather than all.

So especially since, as somebody pointed out -- and it's in your paper -- the ones with high readmission rates are also the ones with high dual rates, if we have to

do that, that's a great place to start, but I don't know why we want to be looking at policies that really wound up with all SNFs having an incentive to reduce rehospitalization rates. And if we also could do that with all hospitals to have incentives, you'd have better alignment of incentives.

I don't know that I'm specifically recommending a wording change, but I'd be interested in thinking about whether we could get quickly beyond high rates to all -- unless somebody sees a problem with going that way. I actually think if you moved to sort of a SNF-specific rate and you don't have the risk adjustments problems quite the same, I would be concerned if you're just taking rates of rehospitalization that -- Tom's point about SNFs with medically complex patients may look like they have high rates. So it puts a real burden on the risk adjuster. And I think there are some other ways to do this which move towards SNF-specific rates where you don't have quite the same problem.

MR. HACKBARTH: So my understanding has been that both in the hospital case and in this recommendation, using excess or relatively high risk adjusted rehospitalization is an acknowledgment that maybe the risk adjustment is not

perfect. So what we want to do is focus any penalties out on the tail of the distribution as opposed to pretend that, oh, we can case by case distinguish between an appropriate rehospitalization and one that is inappropriate.

Is my understanding correct, Carol?

DR. CARTER: Yeah, I mean, I think it's both that the risk adjustment isn't perfect, but also for any given patient these five conditions are potentially avoidable, but that doesn't mean for every single patient --

MR. HACKBARTH: For every one.

DR. CARTER: -- every single one of them should have been avoided. So I think it sort of acknowledges kind of that broader thinking, the broader set of circumstances about why somebody is rehospitalized.

DR. BERENSON: I mean, this is no time to have this discussion. I think if you go to -- I've thought of this much more in the hospital context. If you actually did a warranty approach, which was basically not paying for the readmission, putting the dollars of the readmission into the index admission, make it hospital specific, so that really does a lot to deal with risk adjustment. You're dealing with its own historic distribution of cases. And that's

what the state of Maryland is doing now on the hospital side. Again, this is -- I think there's an alternative that that kind of an alternative deals with the risk adjustment problem.

MR. KUHN: I support both recommendations. I think they both continue to move us in the direction that we need to be going in.

One question, Carol. I had a chance to read the letter and the proposed legislation, legislative initiative that the American Healthcare Association submitted as part of their comments. The proposal that they put forward, would that fit into kind of the theme of the recommendation we're making here? Or would that be a response to our recommendation or would that fit into that them?

MR. HACKBARTH: [off microphone] Why don't you describe it a bit further.

MR. KUHN: As I read it, I think it sets out a multiyear rehospitalization proposal rather than going, as we've talked about, you know, the preventable areas, the clinical areas, it goes in kind of more of with the specific dollar savings and target in mind. And it seems to be said that, you know, let's hit these dollar savings targets, and

when we hit those -- you know, maybe I'm mischaracterizing it, but, you know, we're okay now, we've hit those targets, rather than kind of going in and looking at where are the high-risk areas, let's focus on those, and then whatever dollars ensue from there. So it kind of goes at it from a different direction. But I wanted to see if we thought that might fit into kind of the parameters of what we've said in our recommendation.

DR. CARTER: It does. It's an all-cause measure so it's a little different. You're right in that the legislation details sort of target savings. My understanding is that they're creating sort of facility-specific base and then sort of expected and then measuring individual facility performance against that. And so that's a little different approach than this. They do differ. I mean, obviously, they're both -- it's a response to try to reduce rehospitalizations, so in that sense they're trying to get at the same problem. But on the technical side, they are different.

DR. HALL: I'm in favor of both of these, and I would say when I first heard about this, I was very cautious and wondered about unintended consequences, bad

consequences. But as I look at this now, I see a lot of unintended good consequences coming out of all of these, and I'm actually very excited about it.

Just starting with number two, this maybe is a first step, as Bob was talking about, to get a little better alignment between the hospital world, the doctor world, and the SNF world about the implications of readmission and, therefore, to really start to look much more carefully at what are some strategies to make improvement. Anyone who has worked at this interface between these two facilities will tell you, unless they've been asleep at the switch, that it's one of the most dangerous times for particularly vulnerable and frail older people in their lives, and that a lot of the improvements that are going on in the hospital don't really reach the SNF. A good example would be we do a lot of medication reconciliation in hospitals now with electronic medical records. There are very, very few nursing homes that can accept that type of data electronically. So what generally happens is that the very sophisticated record gets transcribed on a little piece of paper, as it's always been, and is slipped into a folder and sent over.

Because everybody now is kind of on the same page, the readmissions need to be explained and have to have a plausible medical reason. I think this is absolutely terrific.

Another thing that it starts to address is this whole issue of hospice care and explaining to individuals, Medicare recipients and their families, what these choices look like vis-a-vis rehospitalization. Joanne Lynn and others have done studies that have shown that that conversation doesn't take place in anywhere near the frequency that it has to. So I think this is really good.

I wouldn't worry about whether we're all inclusive or not or whether we catch them all. I think this is a really good start and has a little temporizing effect.

As far as number one is concerned, it's probably a good thing that these margins are as high as they are and that we're really moving into 2014. I think it will give the industry an opportunity and a little bit of a cushion to start to take a very hard look at some of the major flaws in SNF, which, as far as I'm concerned, is staffing and staffing that has a turnover sometimes in excess of 50 or 60 percent per year. So the quality measures of one year

relative to the staff may not reflect what the situation is like the next year when there have been these changes. It's a revolving door.

And so over time I think we might be able to actually improve a lot of things that seem to have been quit elusive right now. I'm on.

MS. UCCELLO: I support the recommendations.

MR. GEORGE MILLER: Yeah, I support the recommendations. Much of what I would have said has been said, so I'll save time.

DR. STUART: Yeah, I have a couple of points. One, I want to emphasize what Bob had to say about the importance of hospitalization among duals. In fact, this gets to Cori's point about what are the financial incentives here. And the strongest financial incentive is for somebody who is in a long-term stay in a nursing home to be admitted to a hospital and then come back at a much higher paid SNF rate.

And so in a sense, what we're really interested in is reducing the rate of hospitalizations from SNFs, from long-term care facilities. Whether they happen to be a rehospitalization of the initial hospitalization or not is I

think almost secondary. What we're really trying to do is to reduce potentially avoidable hospitalizations, whether they're the five, or whatever they are. You know, I may be veering us off a little bit on this, and I'm not going to -- you know, I think this is probably best handled through the text, and I do support both of the recommendations.

The one thing I'm a little concerned about in terms of the text is the attempt to provide kind of a surrogate for what we have on the hospital side for an efficient provider. I'm less sanguine about that in the long-term care setting than I am in the hospital setting.

When we think of efficiency, we think of technical efficiency, and, you know, if you know the long-term care world, I mean, that's not unimportant. But what's really important is patient centeredness, and so if you've distinguished between good nursing homes and really lousy nursing homes, much of that focuses on whether the care is perceived as being resident centered or not.

And so I'd like that to be reflected at least in the language here and think about if you had a broader base of what is really quality from the standpoint of the resident, whether you might re-sort nursing homes according

to whether they were, quote, efficient or not in reaching those endpoints.

DR. CASTELLANOS: I, too, support both. I agree with Scott, these margins are -- he used the word "outstanding." I would use a different adjective, but that's okay.

One of the concerns I have is the medically complex patient that's in the hospital and getting that person into some post-acute care setting. We have a real difficult time doing that. In our community we don't have long-term hospitals. One of the comments that Kate made -- and I really like it, and I think we need to not just go from here but go further -- is focus more in the direction we're going and consider some kind of a large bundle, whether it's an ACO, however you want to put it, where we can really address this issue and get away from the silo effect that we're dealing with.

The rehospitalization, I totally agree with for the reasons that are mentioned, plus they need skin in the game, too. They really need some skin in the game. But I really like the direction we're going, and I would like to support Kate's comments about even going further.

MR. HACKBARTH: So as you well know, the ACO program is in the process of being launched. Then in addition to that, there are the pilots mandated under the Affordable Care Act of bundling around hospital admissions in particular. And I think the design work on those is still underway, but certainly one of the models being discussed is combine the hospital admission with post-acute care to create one bundle and eliminate the silos and have somebody manage across that continuum.

MR. GRADISON: I support both recommendations.

DR. BORMAN: I support the recommendations. I would agree with Scott and his adjective of "spectacular." I guess my frustration -- and he expressed frustration about the silos. I'm just frustrated at our seeming inability to dent this despite multiple years of increasingly -- what are, I think, trying to be increasingly measured, more strong recommendations. And I'm just wondering what, if anything, further we can add or do to make some change now, particularly as we look at our matrix for consideration of the entire system. The numbers that pop out about this pop out in a couple of areas, I would imagine for most of you, and why we cannot in a time of such fiscal constraints move

ahead -- and absolutely the rebasing now I think is really just an imperative, and I applaud moving forward in that.

The other comment I would make is that echo that was made earlier in terms of consistency about identifying where cost shifting is part of the rationale and us sending a consistent message that using Medicare dollars to subsidize other things, all the levels of inequity that that represents, and maybe we need a set piece that every time it comes up we put the same thing in there over and over in the hope that repetition will hit some of the blockheads, because I think that's where we have to go to be consistent about it, that it's just not okay in any particular place, and this is particularly one of them, and while I'm hugely sympathetic to the notion that many people don't have a clear plan for long-term care needs, that's not what the Medicare program is directed at doing, and we need to be stewards of that program appropriately. If we need to separately say a message that this is a glaring thing that keeps influencing the program in this way, that's great. But I think we cannot resolve that through the Medicare program. I just want to be very careful that in raising the, well, we've got all these silos, it would be great to

make a big post-acute care policy, dah, dah, dah, that's great. But let's not let that divert us from in the here and now we really need something to change about this. And I think the strongest evidence base that we have circles around the need for rebasing and basing this on the characteristics rather than the therapies delivered.

MR. HACKBARTH: Okay. Thank you. Well done, Carol.

We are now onto home health services.

[Pause.]

MR. HACKBARTH: I thought you folks would tire out, and we would therefore close the gap between the schedule and where we are --

DR. BORMAN: [Off microphone.] We ordered pizza online.

MR. HACKBARTH: That must be. There must be some explanation for this.

Evan.

MR. CHRISTMAN: Good afternoon. Now, we are going to look at the framework as it relates to home health, and recall that last year, we made four recommendations that would have major implications for the benefit. Two of these

related to payment.

First, we recommended that the Secretary stop using a PPS design that rewards agencies for providing more therapy visits in an episode and instead uses patient characteristics to set payment. Implementing this change would have the effect of raising payments for non-therapy episodes and lowering them for therapy episodes. This recommendation would be budget neutral in aggregate.

Second, we recommended a phased rebasing of the 60-day payment rate to make it equal to the cost of the average episode. This would lower payments and a significant reduction would be necessary, as payments have exceeded costs by an average of 17.5 percent since 2001. We recommended that the rebasing be implemented concurrently with the recommended changes for therapy I just mentioned. This would ensure that the distribution of payments among agencies is more appropriate at the lower level rebasing would establish.

The other two recommendations were measures to assure appropriate utilization. We recommended a copay for episodes not preceded by a hospitalization or post-acute care stay, and we also recommended that the Secretary launch

aggressive investigations and enforcement actions in areas with aberrant patterns of home health utilization.

In the forthcoming presentation, you will see that most of the indicators of payment adequacy for this year are not significantly different from the indicators you looked at last year. With this in mind, the Chairman's draft proposal for 2012 is to reprint our 2011 recommendations, and I will touch on this again at the end of the presentation.

As a reminder about the scope of the benefit, Medicare paid about $19 billion for home health services in 2010 and the program provided about 6.8 million episodes to 3.4 million beneficiaries in 2010.

And again, here is our framework. It is similar to the one that you have seen in earlier presentations today. We begin with supply. As in previous years, the supply of providers and the access to home health care 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 nine or more. While there are some areas that lack home health agencies, they are relatively few in number.

Turning from access to supply, the number of agencies was over 11,600 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. There was a net increase of 650 agencies in 2010, with 831 agencies entering the program and 181 leaving.

Supply and the growth in supply does vary among agencies. For example, in terms of supply, New Jersey averages less than one agency per 10,000 beneficiaries, while Texas averages over nine agencies per 10,000 beneficiaries.

This year, we looked at rural and urban utilization for home health as a part of our examination of rural policies. The review, similar to the data you see here, did not show significant differences in access for home health between rural and urban on average. Looking at the top row, there was a small difference of one episode per 100 beneficiaries in the rate of use.

Comparing different classes of rural areas, there is, again, not much difference in the average amount of utilization. It is not shown here, but we also looked at

the ranges in utilization within these categories and found a similar degree of variation within the urban rural and rural subcategories.

However, while the level of average utilization was similar, the mix of services did vary. Thirty-seven percent of the episodes in urban areas qualified for extra therapy payments compared to 30 percent for rural areas. Conversely, 63 percent of the episodes in urban areas were for non-therapy services compared to 70 percent for rural areas. In past work, we have reviewed how the PPS design may make therapy more profitable. The higher rate of therapy use in urban areas may reflect, in part, a stronger reaction to this incentive.

We also examined utilization for less populous rural areas, referred to as frontier. These counties averaged 9.4 episodes per 100 beneficiaries.

In other work, we have reviewed how utilization of home health tends to vary more between different regions or States than it does within regions. Low use rural areas tend to be located in States or regions with low use urban areas and vice-versa.

Now, Medicare started paying a three percent add-

on for episodes in rural counties in 2010, an effort intended to improve access. However, the variation in utilization among rural areas raises questions about the effectiveness of the add-on's design. In some regions, rural areas have the highest utilization. For example, 21 of the top 25 counties in utilization are rural. While rural counties are also among some of the lowest utilization counties in the country, the way the add-on currently operates, the majority of payments go to the higher utilization rural counties.

Now, the bottom of this slide again notes that non-therapy services are provided more frequently in rural areas, as you saw in the last slide. This is critical, because under our recommendations for changes to the case-mix system, payment for non-therapy services would be increased. Consequently, rural areas which provide more of these areas would see a substantial payment increase. Urban areas, which generally provide more therapy services, would see a decrease.

Next, we look at volume. Use of the home health benefit has increased significantly in the last eight years. The number of users has increased from 2.5 million users in

2002 to 3.4 million in 2010, reaching almost ten percent of fee-for-service beneficiaries. The number of episodes has risen from 4.1 million in 2002 to 6.8 million in 2010, a growth of more than 50 percent. And the growth in episodes per user has been substantial, rising from 1.6 episodes per beneficiary in 2002 to 2.0 in 2009 and it remained at about this level in 2010.

The home health PPS currently uses per visit payment thresholds that increase episode payments when additional therapy visits are provided. In past years, we have shared with you utilization trends that show agencies have changed the amount of therapy they provide based on these thresholds. In years when CMS has revised the therapy payment thresholds to redistribute payments, agencies have increased the volume of episodes with higher payments after the revisions and decreased volume for the episodes with lower payments after the revisions. These timely shifts in volume suggested that financial incentives may be influencing the amount of therapy services provided to home health patients.

In addition, we found that agencies which provided more therapy episodes have better margins. Based on these

findings, we recommended that CMS eliminate the therapy thresholds and pay for this service based on patient characteristics, similar to how it pays for all the other services covered under the home health PPS. This change would generally raise payments for several categories of provider that have lower than average margins, such as non-profit hospital based, and as I mentioned earlier, rural agencies.

CMS has made some changes to the PPS in 2010, but they do not obviate the need for the change we recommended last year. Similar to our recommendation, the changes CMS made had the effective of raising payments for non-therapy services and lowering them for therapy. However, the redistribution was likely smaller than what would occur under the Commission's recommendation. Also, CMS still retained the per visit thresholds, so the PPS still provides a financial incentive for agencies to provide more therapy visits.

Next, we will look at quality. This year, we show a new measure of hospitalization that is based on home health and hospital claims and it shows that, on average, on a risk-adjusted basis, hospitalization has declined from 27

to 25 percent. For the functional measures available through Home Health Compare, we see that among those patients not hospitalized at the end of their home health episode, the majority of patients improved on most measures in 2011.

Next, we will look at capital. It is worth noting that home health agencies, even publicly traded ones, are less capital intensive than other health care providers, and also relatively few agencies are part of publicly traded companies. Financial analysts have concluded that the publicly traded agencies have adequate access to capital, though because of the payment reductions in the PPACA and recent payment regulations, the terms for credit are not as favorable as prior years.

For agencies not part of publicly traded companies, the continuing entry of new agencies indicates that smaller entities are able to get the capital they need to expand. As I mentioned earlier, over 800 new agencies entered Medicare in 2010.

Next, we turn our attention to margins for 2010. You can see that the overall margin for freestanding providers is 19.4 percent. However, there is significant

variation in the margin. For example, the agency at the 25th percentile had a margin of three percent, while the agency at the 75th percentile had a margin of 27 percent. Margins for providers that primarily served urban patients were 19.4 percent, while they were 19.7 percent for agencies that primarily served mostly rural patients.

For profit margins equal 20.7 percent. The nonprofits were 15.3. These margin estimates are our starting point for estimating 2012 margins. These numbers highlight two concerns that the Commission has had for many years, that home health margins have been excessive and that there is a wide variation in financial performance.

I would note that we only report margins for freestanding providers here. Hospital-based providers, whose margins were included in those reported during the review of hospital payments this morning, averaged a margin of negative 4.7 percent in 2010.

We also looked at margins by rural subcategory, and here, you can see that, on average, rural margins for providers in the subgroups are not significantly different than the overall margins. Micropolitan counties had the lowest margins at 18.7 percent and rural counties not

adjacent to an urban or micropolitan area had margins of 20.9 percent.

We estimate margins of 13.7 percent in 2012. This is the result of several expected payment and cost changes. PPACA reduced the marketbasket by one percent in 2011 and 2012 and included a base rate reduction of 2.5 percent for 2011. In addition, CMS reduced payments by slightly less than four percent in 2011 and 2012 to account for changes in coding. Also, as mentioned earlier, there is a three percent add-on in effect for rural areas in 2012 through 2015.

These reductions will be offset by other favorable trends that increase payments or keep costs low. We assume a payment increase of one percent in 2011 and 2012 due to expected case mix index increases. Also, annual cost growth has been low traditionally in home health and we have even seen costs fall in some years. We assumed cost growth of half a percent in 2011 and 2012.

In conclusion, here is the summary of our indicators. Beneficiaries have good access to care in most areas. The number of agencies continues to increase, reaching over 11,600 in 2010. The number of episodes and

rate of use continues to rise. Quality shows improvement on most measures. The access to capital is adequate. And the margins for 2012 are projected to equal 13.7 percent.

Since our indicators are largely unchanged from last year and our payment recommendation last year included guidance for payments in 2013, the Chairman has proposed that this forthcoming report reprint the recommendation you approved last January.

To recap, the payment recommendations had two key components. First, revise the PPS to eliminate the per visit therapy thresholds and base payment for therapy on patient characteristics. Agencies that provide more non-therapy services, which generally have lower than average margins, would see payments increase. Agencies that provide more therapy services, which generally have higher than average margins, would see payments decrease.

Second, we also recommended that the Congress begin a rebasing of home health payments in 2013, a year earlier than current law. Given the financial performance of this industry, waiting one more year to begin rebasing did not seem necessary. To ensure appropriate payment during rebasing, we indicated that the revisions to the case

mix I just mentioned should be implemented as soon as possible, either before or during rebasing.

This completes my presentation. I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Evan.

And so just to be clear, what I am proposing here is that we simply rerun the recommendations from last year without revoting. This is something we have done from time to time in the past when, literally, we are proposing the same thing over again.

So it's Karen's turn to go first, right? Clarifying questions. Ron.

DR. CASTELLANOS: Just two simple ones. These recommendations we made last year were presented, I thought, very well. Where is it going in Congress? Has there been any feedback on that?

MR. CHRISTMAN: Sure. I think the one that we have recommended -- we have recommended rebasing for a number of years now --

DR. CASTELLANOS: Right.

MR. CHRISTMAN: -- and the PPACA has a rebasing in it that starts in 2014 and sort of spreads it out over four

years, and every year, they would ratchet it down, but those ratchets every year would be offset by the marketbasket increase.

So our policy -- it's designed to bring their payment down to the level of costs. If you look at what's in the PPACA, it looks like, with all the offsets and the way they've spread it out, it's not quite clear that they would get to that level. So what this recommendation would do is it would pull the reduction forward in time and I think it has a better chance of getting closer to equaling costs.

DR. CASTELLANOS: Second question, and I've asked it last year and I'll ask it again this year, why are the hospital margins so different than the freestanding?

MR. CHRISTMAN: The main -- the biggest difference between hospital-based and freestanding facilities that we have found is not the patients, it's the cost per visit. We've done some digging around on this and we really haven't come up with any kind of real answer as to why the hospital-based have a higher cost per visit. We've wondered if there's something going on with cost allocation, but I honestly can't say that we found a smoking gun there.

The thing to keep in mind is that the therapy changes we recommended last year, the numbers I showed you, would put -- increase payments for hospital-based agencies by about eight percent, and that would occur because the hospital-based agencies do a lot more non-therapy and the payments for those episodes would go up by a fair amount. So that's, I think, where the hospital-based issue is.

MR. HACKBARTH: [Off microphone.]

DR. BERENSON: Yes, let me ask, have you ever run the Medicare margins by State or location of the home health agency?

MR. CHRISTMAN: It's been a while since we -- I don't think we've ever looked at it by State. Sometimes we do --

DR. BERENSON: By region.

MR. CHRISTMAN: -- look at it by the broad census divisions, but it's been a while since I looked at that.

DR. BERENSON: I mean, this is probably a round two comment, but the rural-urban distinction seems to be less important than where it's going on, and I'm wondering what we might be able to learn from that.

MR. BUTLER: Just a reminder that here the

principle is we're going to pay based on cost. So there's yet another way to set things in effect, as opposed to efficient provider or another -- but we passed this, I agree with it, but it's a reminder we've got to really talk through philosophies at some point.

DR. MARK MILLER: There was something, and Evan knows this, too, so this is a couple years ago now, which may be why some of it has faded. It doesn't negate your question, though. It's sort of what's the principle.

The big thing here was when we went and started looking at this -- and what had happened historically is we were coming back year after year saying zero, zero update, and the Commissioners started saying, why aren't we looking at the underlying rates, so Evan -- we -- Evan -- started looking at the underlying rates, and one big finding was the initial episode, 60-day episode, was built on 33 visits. And when we went and looked at it, it's now 22 visits, although the mix of the visits had changed and so we adjusted for that and said, why don't you use that as a benchmark to move to your rebasing.

And so there was something at that point -- it was in our first outing and all the rest of it. That's what

sort of stood out at that point in time. Your question, I think, still stands, though. What's the principle that guides this thing.

DR. DEAN: [Off microphone.] Second round.

DR. CHERNEW: When you do this, do you have the data on when the particular home health agency sort of started? So there's been this big growth in home health agencies that you note, so there's a bunch of new ones and a bunch of old ones. Do you know when you do this whether the agencies you're looking at are sort in that "we just entered" group or whether they're the "we've been around for a long time" group?

MR. CHRISTMAN: I don't think I've looked at it that way. We could look at that.

DR. MARK MILLER: [Off microphone.] Do we have the capability to --

MR. CHRISTMAN: I'm sorry. We do, yes. We do. We just haven't looked at it.

DR. MARK MILLER: Is your thinking that they're less profitable when they start, or --

DR. CHERNEW: Well, my thinking is that the concern here is that the rates get driven down and you get -

- because quality is so hard to measure and there's such heterogeneity here, unlike -- well, it's always hard to measure something. My concern is that you wouldn't want to lower payment rates in such a way that you would have new ones coming in that would maybe practice differently and have lower costs and maybe higher margins. I have no idea whether this is true or not. This is totally speculative. And others that were there then sort of will get driven out as the rate gets lowered.

And so if you saw that the entrants were different than the established providers, you might worry there's some of this sort of one group driving out the other group or some version of that. I have no idea if that's going on. That's what my question was, just is it possible to look at. I'd need to think about it more. But that would be the big concern you would have, is you have some coming in. We are worried about them. We'll keep lowering the rate down to the lowest common denominator and others would get driven out that were really doing things that we wanted. I have no idea if you could figure that out, but that was why I asked the question.

DR. MARK MILLER: [Off microphone.] It helps to

understand why --

MR. HACKBARTH: Some years ago when Bill Scanlon was on the Commission -- I can't remember if you overlapped with Bill Scanlon --

DR. CHERNEW: [Off microphone.] Yes.

MR. HACKBARTH: Well, then you'll remember that his argument about home health was the product was so elastic and the quality was so difficult to assess that it was an inappropriate area for a fully prospective rate. And he advocated some sort of a blended payment system, part prospective, part based on cost, for that reason.

And actually, we carried that recommendation for a couple of years, but after Bill left, it didn't have any really strong advocate --

[Laughter.]

MR. HACKBARTH: -- and so we gradually got away from it, but --

DR. CHERNEW: There is merit to that basic view one way or another, and the concern in this -- for some reason, at least in my ignorance -- there are other people here that are more experienced than I in this area -- is I seem to worry about that more in this particular area than

in others because of the vast amount of entry and difficulty in measuring a whole series of things, like the appropriate number of visit stuff, and you could envision you could make a lot of money and maybe not provide the level of care we would want.

MR. ARMSTRONG: Just briefly, our previous recommendations for home health dealt with copays and the fraud and abuse. Since this is a payment update, are we going to not speak to those, or --

MR. HACKBARTH: [Off microphone.] We would re-run the full set of recommendations from 2011.

MR. ARMSTRONG: Okay, because that seemed to --

MR. HACKBARTH: Yes.

DR. MARK MILLER: It's our mistake. It was just this is what's related directly to the payment update --

MR. ARMSTRONG: Okay.

DR. MARK MILLER: -- and so we put those up there. But the whole slate --

MR. ARMSTRONG: The whole thing. Okay. Great.

MR. HACKBARTH: Okay. Round two. Karen.

DR. BORMAN: I support the recommendations, and again, this is just sort of a rather frustrating topic

because, again, we have this rather diffuse service that we're having great difficulty getting control of to provide something identifiable and of clear value to the beneficiaries.

MR. GRADISON: I support it, as well.

DR. CASTELLANOS: I support it, as well, but I would like to ask Scott, these margins, what adjective would you describe these margins?

[Laughter.]

MR. ARMSTRONG: What's bigger than spectacular? I don't know.

[Laughter.]

DR. STUART: I support the recommendations.

MR. GEORGE MILLER: I support it.

MS. UCCELLO: Yes, I support re-running them. Maybe this is more of a round one question, but I've been thinking, do MA plans do a better job of kind of controlling this or having better gatekeepers and that kind of --

MR. CHRISTMAN: When I've talked to MA and private insurers, I've had a few conversations with them so I can't answer your question with a great degree of rigor, but they do do things like prior authorization and a little bit of

utilization management. For example, they might approve up to ten visits and reevaluate. And I'm not sure how common it is now, but there are MA plans that do use cost sharing in their benefit design. I think we were -- Carol, are you still here? I thought as part of one of our projects, we were trying to get some MA data or private plan data on their post-acute care use to take a look at this.

MR. HACKBARTH: MA plans, of course, as you well know, there's huge variety in terms of how they operate and how they're organized, and for sort of the looser plans, I think what Evan describes is accurate. For more highly integrated plans, like Scott's or the one that I was involved in -- at least at our organization, I will let Scott speak for himself -- there's a lot of clinical oversight of patients undergoing home health care. They weren't just sent off to home health care and see you later. There was constant interaction between nurses and the patients to make sure that they were getting the care they needed, but no more.

MR. ARMSTRONG: You know, just briefly, I would add, there is a point of view that is different in that hospice is highly integrated to the overall care process and

is seen as an investment made that drives a return on lower costs and better health for the rest of the system. And so it's highly integrated and used, I think, probably in some significantly different ways.

DR. HALL: I support this.

MR. KUHN: I support the recommendation.

DR. BERENSON: I should have done this in round one, but this has round two vibes. The table you had in the paper had a number of counties with share of fee-for-service beneficiaries using north of 25 percent home health. I mean, that struck me as remarkably high. Are there any independent sort of assessments of how many Medicare patients are homebound by a definition rather than they just, if you want the home health service, somebody declares you homebound? There is no benchmark to compare those numbers against.

MR. CHRISTMAN: No, and when we speak with the home health industry, they look at these numbers and say this is questionable. They've even talked about having a sort of a per beneficiary sort of agency-level cap. An agency wouldn't get paid if episodes per beneficiary went above a certain number, because they look at these numbers

and I think they have the same reaction you do.

DR. BERENSON: But all we have is sort of the empirical data from across the country of how many people are getting the home health benefit. It gives us some little clue as to how many people would be homebound, although presumably -- well, no. I will leave it at that.

I support the recommendations.

MR. HACKBARTH: Okay.

DR. BAICKER: I support the recommendations.

DR. NAYLOR: I support the recommendations.

MR. BUTLER: Support.

DR. DEAN: I support the recommendations. As some of you know, this has been an area that I have been concerned about for a long time, because I live in an area that is just exactly the opposite of those counties that are described and I was a little concerned about the wording, that it didn't really bring out the fact that there really are areas where this service is really not very available. I did the quick calculation. If we've got 45 million or whatever people in the Medicare program and we're serving 99 percent of them, that still leaves almost a half-a-million people that don't have access to the service.

A while back, Evan got me some data broken down by States and in terms of the cost per beneficiary. It's interesting. The two lowest cost States in terms of cost per beneficiary are Hawaii and South Dakota. I cannot imagine two States that have less in common, but that's what the data show.

And the cost per beneficiary, there are massive differences. It's about an eleven-fold difference between the cost per beneficiary in the high-cost States as opposed to the low-cost States, and the issue of the percentage of beneficiaries that are using the service in the low-cost States is down around two percent. And I was struck, too, by the -- I mean, if you've got 30 percent or a third of Medicare beneficiaries using the service, that really raises a concern. I think it just speaks to the fact, which has already been mentioned, that this is a service that's hard to define. It's hard to monitor. And it's a terribly valuable service, but it's very poorly distributed, or maybe that's too strong a term.

I guess that in looking at these cost data broken down by States, really, the main difference is the share of beneficiaries that are using the service. That seemed to be

the thing that correlated the most, because the number of episodes per beneficiary isn't really all that different. There is some variation, but it's not huge. But there is huge difference in terms of the share of beneficiaries that are actually using the service.

So how you respond to that, I'm not sure. I mean, in our area, we've had no new agencies in the last five years. In fact, we've got fewer agencies in South Dakota now than we had five years ago. And the other thing that's different is that about 80 percent of our home health agencies are hospital-based. We have very few freestanding, and they're only in two communities in the State, basically.

So I just say this because it just -- we need to be careful about, and I guess I've said this before, about making judgments based on averages because there are extremes in those averages, so whatever.

I support the recommendation.

MR. HACKBARTH: And, Tom, you'll recall that as we looked at geographic variation and dug progressively deeper into that, one of the findings was that a surprisingly large portion of the variation in cost per beneficiary, or actually in service use per beneficiary using our weighted

methodology, was in the post-acute services and DME. So the variation in physician and hospital was relatively smaller. There's still variation, to be sure. But the variation that was attributable to differences in home health and other post-acute providers and DME was really strikingly large.

DR. DEAN: [Off microphone.] No, I agree.

MR. HACKBARTH: Mitra.

MS. BEHROOZI: I think the first time around, I abstained from the recommendation because of my concerns about the component of the recommendation dealing with the copayment. But it's passed, so I think I can still remain principled and say I support restatement or whatever, re-running the recommendation because it's already the Commission's recommendation. I don't have to --

MR. HACKBARTH: Yes.

MS. BEHROOZI: -- dice it and slice it. But anyway, that's okay.

MR. HACKBARTH: We could actually have a footnote that says that you support it this time.

[Laughter.]

MS. BEHROOZI: But I do want to say, actually, I think that the urgency is increasing to do the revision of

the PPS. I think that we keep pouring money down some drain somewhere. I mean, 27 percent margin. Twenty-seven cents of every dollar that Medicare is spending is not doing anything for patients, right, and it's not building bricks-and-mortar facilities that are needed for stand-by capacity or anything like that.

Meanwhile, at the other end, whether it's three percent or whether it's close to zero, whatever you want to call it, there are agencies that hopefully are using that money for patients, not spending it on lavish salaries or whatever, but using it to care for patients, to provide more services for patients, and we need to shift that balance to even that out so that the agencies that are doing good -- maybe some of the agencies that have been around longer -- I think the question that Mike asked is a really good one -- that have been motivated by mission to stay in the game, even though they're not making these dramatically beyond fantastic margins but are down at the low level, the revision is just critical and needs to happen as soon as possible. Thank you.

DR. CHERNEW: I support the recommendations.

MR. ARMSTRONG: I do, too. I think the only thing

I would add would be, let us not understate how dramatic it was for us to endorse this copay. I mean, it's a big deal issue and we shouldn't forget that.

And second, the provision of home health care is just such a fantastic service. It creates incredible value for our subscribers, and the people who provide this care do wonderful things for people in our program. My hope is these tweaks will help us get beyond it being sort of like a problem and more into really this wonderful component of our overall Medicare benefit, because I really -- it should be seen that way and I hope that we can get there.

MR. HACKBARTH: Okay. Thank you, Evan. Good job.

We have arrived at our last session for today and here we are not talking about updates, but rather about encouraging use of lower-cost medications. Shinobu.

MS. SUZUKI: Good afternoon. In this presentation, I am going to quickly summarize the key points from last month's presentation and present the Chairman's draft recommendation to increase the use of generics by beneficiaries receiving low-income subsidy.

In November, we presented data that show that LIS enrollees fill more prescriptions and the cost of each

prescription is higher, on average, compared to non-LIS enrollees, and the use of more brand name medications by LIS enrollees was contributing to the higher per prescription cost for this population. We also discussed an example of how the LIS cost sharing could be changed to provide a stronger incentive to use generics, which I will come back to in a minute.

A policy based on financial incentives has to be carefully constructed for this population to ensure access to the medications they need, and it should also take into account variations in plan formulary structures, so it should not be too prescriptive as to undermine strategies plans are already using to manage drug use and costs. And finally, given their unique circumstance, the policy should not apply to dual eligible beneficiaries residing in institutions.

Multiple factors can contribute to higher or lower generic dispensing rates among groups of beneficiaries. For example, differences in health status may limit the opportunity for clinically appropriate therapeutic substitutions for some beneficiaries. Prescriber behavior and pharmacy incentives can also affect beneficiaries' use

of generics. And plan formulary design is one of the key tools used by plan sponsors to manage the drug spending. Most Part D plans use cost sharing differentials between drugs on different tiers to steer enrollees to lower-cost drugs, but this tool is not available to manage the drug spending of LIS enrollees. One national plan found the generic dispensing rate for a diabetic therapy dropped by ten percentage points among enrollees who newly became LIS.

Some States require mandatory generic substitution, but based on our preliminary analysis looking at generic dispensing rate across all therapeutic classes, the GDR did not appear to be systematically related to State laws.

Here is the policy option we discussed last month. The key features are, first, the policy should modify the Part D copayment amount specified in law for Medicare beneficiaries with incomes at or below 135 percent of poverty to further encourage the use of lower-cost medications when available in a given therapeutic class.

And second, there should be Secretarial review of the therapeutic classes periodically to determine appropriate classification for implementing the policy.

And finally, the current appeals and exceptions process should remain in effect to ensure access to needed medications.

Cost differentials that make generic prescriptions relatively more attractive can have a strong impact on generic use. As I mentioned earlier, in general, LIS enrollees tend to have lower generic use compared to non-LIS enrollees. Some of the difference in the generic use rate is likely due to differences in health status, but weaker financial incentives faced by LIS enrollees likely account for some of the differences in generic use rate between the two populations.

Generic drugs cost significantly less than their brand counterparts, so policy that encourages generic substitutions, including therapeutic substitutions, which involves switching from a brand name drug to a generic drug that is not chemically equivalent but is in the same therapeutic class, can lower Part D spending without limiting access to medications.

Here is the example we used last month to illustrate how one might structure a policy that would make generic drugs relatively more attractive. The example shown

here is for LIS enrollees with incomes at or below 100 percent of poverty. Currently, these enrollees pay a little over $1 for generics and $3.30 for all brand name drugs, and this is shown in the top portion of the table.

Under the alternative cost sharing structure, the spread between generics and brands would be wider for drugs in classes that have generic substitutions. This is shown in the bottom half of the table. Instead of a $1/$3 cost sharing, we eliminate the cost sharing for generic drugs and increase the cost sharing amounts to $6 for brand name drugs when there are generic substitutes, and this is shown in red.

For brand name drugs in classes with no generic substitutes, cost sharing amounts would not change so that beneficiaries would have the same access to those drugs as under current law.

There are many ways to do this. For example, many plans have separate non-preferred tier for expensive brand name drugs, and CMS may want to allow higher cost sharing amounts to further encourage the use of lower-cost drugs.

Similarly, we are seeing more plans that use non-preferred generic tiers and we may want to allow some

flexibility so that plans can steer LIS enrollees to use the preferred generics.

Your Chairman's draft recommendation, it reads, the Congress should modify the Part D copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs when available in a given therapeutic class. The Congress should direct the Secretary to review the therapeutic classes as part of the formulary review process at least every three years to determine an appropriate classification for implementing the policy.

We expect this to decrease Medicare spending relative to current law and we do not expect any adverse impact on providers or beneficiaries' access to needed medications.

In general, if an LIS beneficiary switched to using generics, it would lower the cost sharing that the beneficiary would pay out of pocket, and studies have shown that lower cost sharing increases adherence to their medication therapy. It would also reduce the costs of providing the Part D benefit for some plans, which would tend to lower the premiums and the subsidy payments Medicare

makes to Part D plans. It may also increase profits for some pharmacies, since generic drugs tend to have higher profit margins than brand name drugs.

And that concludes my presentation.

MR. HACKBARTH: Thank you.

So we have a generally worded draft recommendation and a table with specific dollar amounts. Anything you want to say, Shinobu or Mark, about that approach as opposed to having a more specific recommendation?

DR. MARK MILLER: Yes. And again, I think it's not unlike some of the discussion that we had earlier. We think that there's probably some variation that you could pursue on this. For example, some of the plans that we talked to like to distinguish even among generics -- zero, one dollar, 50 cents even -- to do some steering within there. And so we were thinking that we would be less prescriptive in saying, here is the precise dollar amounts to write into law. Put the general recommendation out describe, describe how you could do it, and put schedules like the one you saw up here into the text, and then let the Congress work through the specifics, or the Congress say this and have the Secretary work through the specifics.

MR. HACKBARTH: Okay. Clarifying questions. Scott. Mike. Mitra. Tom.

DR. DEAN: I think you may have said this, but I didn't catch it. What is the copay on brand name drugs where there is not a generic equivalent?

MS. SUZUKI: Under the alternative policy that we are recommending, or --

DR. DEAN: Either one.

MS. SUZUKI: So currently, the copays for people we are discussing, under 100 percent of poverty, are $3.30 for all brand name drugs.

DR. DEAN: All brand name --

MS. SUZUKI: It doesn't matter whether it has a generic substitute or not. And under the policy, we suggested that if there are no generics, then maybe keep it at the current law level, which is $3.30 for this population.

DR. DEAN: And the people that qualify for this benefit are low income but not on Medicaid, right?

MS. SUZUKI: They're mostly on Medicaid. So LIS subsidy goes up to 135 -- 150 -- I think there is a -- people who pay copays go up to 135. There is a sliver of

people who do pay a coinsurance who are a little higher income. They're not Medicaid. But the population we're discussing for this policy, the majority of them do receive Medicaid.

DR. DEAN: Okay. But, I mean, Medicaid has their own system for copays and so forth, don't they? I mean, are those in conflict at all? I guess I'm not sure how they blend together or how they merge.

MS. SUZUKI: They now receive -- so since 2006, those duals have been receiving their drug benefit through Medicare's Part D program.

DR. DEAN: [Off microphone.] Okay. That's --

DR. MARK MILLER: She was saying Medicaid. They may still be getting Medicaid services for other things, but this is how they're getting their drugs.

DR. DEAN: [Off microphone.] Okay. Got you.

MR. BUTLER: So why 135? Is that the LIS threshold? What --

MS. SUZUKI: That's in the statute for -- so people with income below 135 percent of poverty, they have nominal cost sharing for the drug benefit. So we're trying to play with the copay amounts. These are the population

who this policy would apply. There are people who are in institutions who pay no cost sharing, which would be a separate issue that we are not addressing at this point.

DR. MARK MILLER: Let me give you a quick thing, because it's probably worth --

MR. BUTLER: Yes, but don't test me on it.

DR. MARK MILLER: Okay. So here's a real quick version. Shinobu's come a couple times to the meeting and said, look at these differences in generic use between LIS and non-LIS. LIS is a standard that's written into law at 135 percent of poverty and below. There are set nominal copayments. What we're saying is give a little more play in those nominal copayments by, say, for example, taking down the generics so that you move people to the generics. And so that's why it's LIS and that's why it's 135.

MR. BUTLER: I understood everything except where 135 came from.

DR. MARK MILLER: Oh, from the law, and it was something in 2006, the Part D benefit.

MR. HACKBARTH: Okay. [Off microphone.]

MR. GEORGE MILLER: Just a quick question. If this has the impact we hope it will, why review it every

three years and why not every two years or -- is the magnitude of the work to review it that three years makes more sense? Why not do it every two years to make sure we're on target?

MS. SUZUKI: The Secretary, if he or she sees the necessity, could review this more frequently. We were just suggesting no less than three years.

MR. GEORGE MILLER: [Off microphone.] Thank you.

DR. CASTELLANOS: [Off microphone.] Slide 2, please. Again, just refresh my memory. I think Bruce and myself were talking about it, but why doesn't this apply to dual eligible beneficiaries in institutions?

MS. SUZUKI: Part of the issue is that they're not the ones making the decision --

DR. CASTELLANOS: Right.

MS. SUZUKI: -- about generics or brands, and also that they don't pay copays under current -- they pay nothing under current law. So the copay policy wouldn't apply unless we somehow decide that that's the direction we wanted to proceed. But these are very low-income people who are not making the decision about generics or brands.

DR. CASTELLANOS: Okay. So the person that's

making the decision is the medical director?

MS. SUZUKI: Or, right, the prescriber or --

DR. CASTELLANOS: Okay. I remember several years ago, we talked about that and there is a potential rebate issue. Has that been even talked about?

DR. STUART: [Off microphone.] -- the medical director.

DR. CASTELLANOS: To the institution.

MS. SUZUKI: To the long-term care pharmacies.

DR. CASTELLANOS: [Off microphone.] Is that a problem?

MS. SUZUKI: I think the last report that we did on long-term care pharmacies, we can send this over to you, but the rebate, I think, has become a smaller portion of their revenue, in general. And when we looked at this population in long-term care facilities, their generic use rate was not necessarily lower compared to other populations.

DR. CASTELLANOS: Thank you.

MR. HACKBARTH: Okay. Scott, round two.

MR. ARMSTRONG: Well, I support the direction that the Chairman's recommendation is heading in.

DR. CHERNEW: I also support it. I'm troubled about one thing, though, which is we often talk about all drugs. It has a tone that all drugs in a therapeutic class are kind of the same and we want to push them there. What I would worry about is what would happen to people that tried a generic that didn't work in a particular therapeutic class and now they wanted to use another drug and that drug was more expensive, but now they're stuck paying the higher copay.

So if I had my druthers, and I'm not sure I do, some sort of mechanism that -- if there was really a plan here and a way, you know, Scott was there, Scott might think, you know what? What really we want to do is encourage them to start with a generic, but if there's a problem or some other issue, we'd give them an out or an exception.

So I'm sort of worried about the exception, because I think that it is the case that not all drugs are -- I'm actually going to stop and let Bruce finish because he's going to say something --

DR. STUART: I'm just going to say that that policy is in place. Plans have to have an appeals process.

Now, how well it works is another issue. I don't know. But --

DR. CHERNEW: There's not a lot of cost sharing --

DR. MARK MILLER: [Off microphone.] This doesn't change that.

MR. HACKBARTH: So the issue you're raising, I think it's a very important one. It's not unique to the LIS generic substitution. It's a general one. And the approach in the statute is the one Bruce described, that you can appeal and say, this generic doesn't work for me and I need the brand name and you get it at a comparable copay.

DR. CHERNEW: [Off microphone.] All right.

DR. MARK MILLER: And just to be -- I think the appeal has to be requested by the physician, is that right, Shinobu? Okay, sorry. Didn't mean to put you on the spot.

MS. SUZUKI: [Laughing.]

DR. MARK MILLER: [Off microphone.] Never mind. We can move on.

MS. BEHROOZI: I totally support it. I just wish we could say "zero" in the recommendation language, but oh, well.

DR. DEAN: I support the recommendation. I think

these are -- figuring out the right level is a tricky business because if you --

MR. HACKBARTH: [Off microphone.] For the copays?

DR. DEAN: For the copays, yes, because these are folks where a couple of bucks is going to make a difference, and if they decide to stop their medicines and end up in the hospital, it's bad for them and it's bad for the program. So although the idea that we need to have some kind of steering mechanism is obviously totally appropriate, but I'm -- you know, with the example, I totally support the zero copay on the generics. Raising it on the preferred brands, I'm a little uneasy with, just because I wonder if we could be pushing too hard. But I don't know, you know. Like I just said, it's tricky business. But, basically, I support the direction and the goal.

MR. HACKBARTH: So, Shinobu, do you want to say a little bit about how these dollar amounts were arrived at?

MS. SUZUKI: The examples that we've given? So for the generic drug, we were thinking that it would be zero or something below whatever it is under current law, so 110 for this population. For the plans that have preferred and non-preferred brand drugs, we thought if there are generic

substitutes, we could raise a preferred brand drug to $6 and maybe there should be some flexibility in distinguishing between preferred and non-preferred brand name drugs if plans already have that sort of formulary structure. But it --

MR. HACKBARTH: Any sort of a budget neutrality calculation, that if we go to zero for the generic, to make it equal the same total cost, we have to go to six for the brand?

MS. SUZUKI: There was no intention of making this a budget neutral amount. The amounts -- we were giving this example so that they're no worse off and actually in some cases would have lower out-of-pocket cost if they moved to generic drugs.

MS. BEHROOZI: I think it's an important to say that the $6 only applies if there's no generic -- I'm sorry, if there is a generic available --

MS. SUZUKI: Right.

DR. MARK MILLER: [Off microphone.] Right.

MS. BEHROOZI: -- right? Otherwise, it stays the same as it is in current law.

MS. SUZUKI: Mm-hmm.

DR. MARK MILLER: And really, what we are trying to do is that there shouldn't be large cost sharing for this population, and so if you look at the current law, the multiple is kind of one to three, and we were saying, well, zero, hold the preferred at three, and then maybe you add something like three or more -- a few more dollars to the top end. But it was just that kind of thinking, just to try and get something of a pricing.

DR. DEAN: Getting it high enough to get their attention, but not high enough to stop taking it is, like I say, is a tricky judgment, but I, I mean, it's moving in the right direction.

MR. HACKBARTH: I think Mitra's point is that given that there is by definition a generic alternative here, we've gone to zero for that to really encourage them to take the needed drugs.

DR. DEAN: Yes. I think I didn't completely appreciate that.

MR. HACKBARTH: Peter.

MR. BUTLER: I support the direction.

DR. NAYLOR: I support the direction.

DR. BAICKER: I do, as well, and keeping in mind

Mike's important point about non-equivalence within class, you could imagine language that was flexible enough to let the Secretary do something like allow step therapy, where if the generic didn't work for you, you sort of automatically got the preferred non-generic rate as long as your doctor said you tried the generic. There's a lot of flexibility that you could use to address this important issue that the generic just isn't going to work for some people.

DR. BERENSON: I'm on board.

MR. KUHN: I support the recommendation.

DR. HALL: I support the recommendation.

MS. UCCELLO: I support the recommendation and would suggest that the text surrounding it does -- we can't have the zero in the recommendation, but I think the text should really highlight that it's the zero that's driving things. It's not the difference between the two. It's the zero. And I think we need to stress that in the text.

MS. BEHROOZI: Cori, let's talk about how we could fit it in the recommendation, maybe. We'll talk to you, Shinobu.

MR. BUTLER: I will get with you, too. I like that.

MS. BEHROOZI: Okay.

MR. HACKBARTH: Please do. Feel invited to do that if you have some proposed language.

MR. GEORGE MILLER: I support the recommendation and also what Cori just said, to try to figure out with Mitra and Peter and the man next door to get it down to zero.

MR. HACKBARTH: Bruce.

DR. STUART: I support the recommendation and actually have a question, although I think I know the answer. There are some plans out there that have zero copays for generics and I'm assuming that in those plans that the LIS beneficiaries pay zero. I can't imagine that the plan would set up that LIS has to pay more than LIS. So in that case, it's already there, and some of those plans actually will have therapeutic classes where there are no brands on the formulary at all. So that would mean that there's a huge price difference between the zero and the full cost.

And to get to Tom's point just very, very briefly, studies of LIS and non-LIS, well, particularly LIS, have shown that the use of generics and brands in classes where

experts think there's pretty close substitution, the LIS have much higher rates of brand use, as in statins, PPIs, and a couple of other areas. So, I mean, there clearly is room for therapeutic substitution in these areas.

DR. DEAN: Do those studies give us a clue as to why? Is that the prescriber's decision, or is that --

DR. STUART: Almost all of this work has been done on analysis of fill rates, and so you really don't know what's going on behind the fill rate.

DR. CASTELLANOS: I support this.

MR. GRADISON: I do, as well. Thank you.

DR. BORMAN: I support.

MR. HACKBARTH: [Off microphone.] Thank you, Shinobu. I'm sorry.

We're done with the presentation, so now we will have our public comment period.

MS. McILRATH: Sharon McIlrath, AMA.

I'll make this quick. I have a question. When you look at future years, what's happening with the updates for the different providers, and you have potentially a 10 percent increase 10 years from now in the hospital outpatient rates, and you have -- under your SGR proposal --

a 16.6 percent reduction for some physicians who are doing those visits and a 10 year freeze for some other physicians that are doing that visit, you have a potential of having a 10 percent to a 26.6 percent difference in the rate.

So what rate it is that it's going to be equal to?

MR. HACKBARTH: Would you give your name and organization? And when the red light comes on, that means your time is up, two minutes.

MR. SPERLING: I'll be very brief. My name is Andrew Sperling with the National Alliance on Mental Illness.

NAMI would like to go on record against a proposal that was just approved by MedPAC on dealing with the Part D cost-sharing for LIS and dual eligibles. We are extremely about higher cost-sharing on these most vulnerable and low-income beneficiaries.

We're concerned with the staff presentation where there was sort of -- what we believe -- inaccurate characterization of generic substitution versus therapeutic substitution. There are therapeutic classes, and this appears -- if there is a single generic available in that therapeutic class, then this new higher cost-sharing would

apply.

At least in the case of a typical anti-psychotic medications, we have voluminous studies demonstrating that these products are not therapeutically substitutable within the class. That's precisely why CMS has had policy in place since 2006 requiring the Part D drug plans to include all or substantially all of the medications in those classes on their formularies, because they are not clinically interchangeable.

So we're very concerned that individuals who are on a particular product because of the particular side effect profile and their particular symptom, in order to continue to take that brand name medication, are going to be compelled to have higher cost-sharing imposed on them.

These are dual eligible beneficiaries who have disposable income, for many of them, that is below $500 a month. So we're very concerned about higher cost-sharing, these beneficiaries being singled out for higher cost-sharing.

There's a number of things I will go on writing with MedPAC in terms of the concerns of the characterization of this proposal, but at least on behalf of the National

Alliance on Mental Illness, we're very concerned about this proposal being brought forward by MedPAC.

Thank you.

MR. HACKBARTH: Okay. We are adjourned until 8:15 tomorrow morning.

[Whereupon, at 5:44 p.m., the meeting was recessed, to reconvene at 8:15 a.m. on Friday, December 16, 2011.]

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 16, 2011
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
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
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. Our first session this morning is on payment adequacy for hospice services. Kim?

MS. NEUMAN: Good morning. I'm going to present the latest hospice data for your consideration of payment adequacy. Before I do that, I'll provide a little background on hospice and summarize the Commission's prior recommendations.

The Medicare hospice benefit provides palliative and supportive services to beneficiaries with a life expectancy of 6 months or less that choose to enroll.

In 2010, over 1.1 million beneficiaries, including about 44 percent of Medicare decedents, received hospice care, and Medicare paid about $13 billion for that care provided by over 3,500 providers.

This next slide is a summary of the Commission's prior work and recommendations on hospice. In the last decade we've seen several trends: rapid market entry by for-profit hospices; an increase in length of stay for patients with the longest stays; and higher profitability among hospices with longer stays.

That higher profitability reflects a structural issue within the Medicare payment system that makes long stays in hospice more profitable than short stays.

In 2009, the Commission recommended revising the hospice payment system to better align payments with the service intensity of care throughout an episode. PPACA has given the Secretary the authority to revise the payment system as she determines appropriate in 2014 or later. Since it's unclear how this will evolve, we plan to reprint the recommendation in the March 2012 report.

Another issue our prior work identified was inadequate accountability in the hospice benefit, such as issues with physician certification of patient eligibility, and also questionable relationships between some hospices and nursing homes. To help address this, the Commission made several accountability recommendations. Most have been implemented. As of October 2009, a physician narrative is required on certifications and recertifications. As of 2011, a face-to-face visit is required prior to recertification of patients with long stays. And the OIG has several studies on hospice and nursing home issues underway or completed.

The Commission also made a recommendation for focused medical review of all stays beyond 180 days for hospices with unusually high rates of long-stay patients. PPACA adopted a similar requirement, but it does not appear that it has been implemented yet, so we plan to reprint this recommendation in the March report.

So now to look at the latest hospice data using our standard update framework that's used across the sectors. We'll look at the supply of providers, volume of services, quality, access to capital, and payments and costs.

This first chart shows the substantial growth in the supply of providers that has occurred since 2000 and the particularly rapid growth among for-profit providers. The number of providers continued to grow in 2010.

The next chart shows substantial growth in hospice use among Medicare decedents, suggesting increased awareness of hospice and access to care. Between 2009 and 2010, hospice use among decedents increased 2 percentage points, from 42 to 44 percent. And across all beneficiary and demographic groups we examined, hospice use among decedents increased between 2009 and 2010.

Over the last decade, hospice use has grown particularly rapidly among beneficiaries age 85 and older. In 2010, slightly more than half of decedents age 85 and older used hospice.

Hospice use increased in 2010 for all racial and ethnic groups, but the use rate among minorities remains lower than whites.

Looking at use by type of county, decedents that lived in urban counties have higher rates of hospice use than decedents in rural counties. And you can see the use rates decline as the degree of rurality increases. However, all types of counties have experienced increased use of hospice.

This next chart shows the growth in the number of hospice users, up 6 percent in 2010 compared with the prior year.

Average length of stay among decedents grew from 84 to 86 days between 2009 and 2010, with growth in average length of stay slowing from the more rapid rates earlier in the decade.

While growth in average length of stay over the last decade among decedents has been driven largely by

growth in length of stay among patients with the longest stays, short stays have changed little. Median length of stay among decedents held steady at 17 days for most of the decade, but edged upward slightly in 2010 to 18 days.

Not shown in the chart, we've also looked at length of stay for hospice users who were not decedents -- meaning those discharged alive or still a patient at the end of the year. Length of stay for this group is much higher than for decedents, but appears to have declined modestly between 2009 and 2010.

As we've talked about previously, both very short stays and very long stays are a concern. With short stays there is a concern that patients do not get the full benefits of what hospice has to offer. With very long stays, especially when they're concentrated among individual providers, there's concern that some providers may be inappropriately using the benefit.

There's a group of hospices, those that exceed the Medicare aggregate payment cap, that much higher lengths of stay than other providers. Recall that the aggregate payment cap is one of the constraints that Congress put on the hospice benefit. It effectively limits the average

payment a hospice can receive per patient. If the total amount paid to a hospice in a year exceeds the number of patients times the cap amount -- about $23,000 in 2009 -- the hospice must repay the difference.

In 2009, we estimate about 12.5 percent of hospices exceed the cap up from roughly 10 percent in 2008. Cap overpayments totaled just under 1.7 percent of total Medicare hospice payments in 2009. A change in the cap methodology affects our ability to precisely estimate these overpayments, but we think, if anything, our estimates for 2009 are a little bit high.

As discussed in more detail in your mailing materials, cap hospices are almost entirely for-profit, have very stays, and have substantially more patients discharged alive compared to other hospices, even within the same diagnosis categories. And they have very high profit margins before the return of cap overpayments.

Lastly, as we have seen in past years, we found no evidence that the cap impedes access to care.

Next, quality. We currently do not have any data on which to assess quality trends. In 2013, hospices will begin reporting quality data or face a 2-percent reduction

in the update beginning in fiscal year 2014.

CMS has established two quality measures for 2013. The first measure focuses on pain management, specifically whether patients who were uncomfortable due to pain at admission were comfortable within 48 hours.

For the second measure, hospices will report whether they track at least three patient care quality measures and what those measures are. This will help CMS assess feasibility of additional measures for the future.

NQF is currently in the process of considering additional quality measures for endorsement, so that may be a source of more measures as well.

In November, we convened panel of hospice quality experts -- providers, researchers, clinicians -- to find out what they thought were the most important indicators of hospice quality. Most panelists viewed bereaved family member surveys as an important quality indicator for hospice. In terms of symptom management, they generally supported the pain measure adopted by CMS and also thought process measures surrounding shortness of breath treatment were worthwhile. Other aspects of care some thought indicated quality include the amount of staff contact hours

with patients, the breadth of services offered, evening and weekend responsiveness, and staff certification and turnover. Panelists also mentioned some possible claims-based measures that might be flags of potentially substandard care -- for example, hospices with few visits in the last days of life.

So in terms of access to capital, overall access to capital appears to be adequate. Hospice is less capital intensive than some other providers.

Free-standing hospices appear to have adequate access to capital. As you saw earlier, there's a continued influx of for-profit providers, and there has also been modest growth in free-standing nonprofits.

Publicly traded hospice chains generally have favorable financial reports and adequate access to capital, and there have been more hospice transactions by private equity firms in the first half 2011 compared to 2010. And provider-based hospices have access through their parent institutions.

So this brings us to margins. This slide shows the trend in margins, and as you can see, the margin has really oscillated over the last several years in a pretty

narrow range. In 2009, the aggregate Medicare margin is 7.1 percent, up from 5.1 percent in the prior year. And a couple points about the margin.

First, underneath the aggregate margin, there's wide variation. In 2009, the 25th percentile is minus 13.7 percent, the median is 5.3 percent, and the 75th percentile is 20.2 percent.

Second, just a reminder about how we calculate margins. We assume cap overpayments are fully returned to the government, and we exclude non-reimbursable costs, which means we exclude bereavement costs and the non-reimbursable portion of volunteer costs. If those costs were included in our margins, it would reduce the margin estimates by, at most, 1.5 percent and 0.3 percent respectively.

This next chart shows the difference in margins by type of provider. First you'll see that free-standing hospices have higher margins than provider-based hospices, and that's in part due to the allocation of overhead from the parent provider. If the provider-based hospices had similar cost structure to free-standing hospices, their margins would be higher, and the industry-wide Medicare margin would be as much as 1.8 percentage points higher.

We also see that for-profit hospices have higher margins that nonprofits, 11.4 percent versus 3.4 percent. But if we just look at free-standing providers whose costs are not affected by the allocation of overhead, we see nonprofits with a margin of just over 6 percent.

Finally, below-cap hospices have margins of 7.6 percent, a half a percent higher than the industry-wide margin.

Above-cap hospices' margins were 1 percent assuming the full return of overpayments. Without the return of overpayments, their margins would have been 18 percent.

This next chart shows the relationship between margins and average length of stay and site of care.

The chart on the left shows that as average length of stay increases, hospice profitability increases. You see a slight dip in the margin for hospices in the highest length of stay quintile because some cap hospices are in that group, and our margin estimates assume the full return of overpayments. The margin for the highest length of stay quintile would have been nearly 17 percent without the return of overpayments.

On the right side of the slide, we see how margins vary by percent of a providers' patients in a nursing facility. Hospices with a higher share of patients in a nursing facility have higher margins.

As you'll recall, the Commission recommended that the OIG study hospice care in nursing facilities. The OIG recently completed a study on hospices that focused heavily on nursing home patients. They found these hospices tend to be for-profit, have longer lengths of stay, and treat patients who need less complex care. The OIG made two recommendations: one, that CMS monitor hospices that focus on nursing facilities; and, two, that CMS reduce the payment rates for hospice care in nursing facilities.

We also have margins broken out by rural categories, and we have classified hospices based on the type of county in which the largest share of their patients reside, and hospices predominantly serving urban counties had a higher aggregate margin that those predominantly serving rural counties, 8 percent versus 3.7 percent.

Among those predominantly serving rural counties, we see higher margins for rural nonadjacent counties than for other types of rural counties.

What's driving the higher margins among hospices serving rural nonadjacent counties is hospital-based providers. Free-standing providers have pretty similar performance across the three types of rural counties, but hospital-based hospices have substantially better margins for rural nonadjacent counties than others.

We also look at margins for hospices with at least 10 percent of their patients residing in frontier counties, and we see an aggregate margin of about 8.8 percent. It's important to note that there's great variation underneath the aggregate figure. The median is slightly above zero, and there are some hospices that have very high margins and others that have very low margins.

This brings us to the 2012 margin projection. To project margins in 2012 we make several assumptions. We assume full market basket update for 2010 through 2012. Wage index changes in 2010 and 2011 reduce payments slightly and in 2012 increase payments slightly.

Reductions in the wage index budget neutrality adjustment factor in 2010 to 2012, which is the first three years of the seven-year phase-out, and that amounts to about a 1.6-percent reduction. And additional costs for face-to-

face visit requirement for recertification of long-stay patients beginning in 2011.

Taking all that into account, and assuming cost growth generally in line with market basket, which is a conservative assumption, we project a 2012 margin of 5.1 percent.

In 2013, one policy to note is the continued phase-out of the wage index budget neutrality adjustment which will reduce payments by an additional 0.6 percent percentage points.

So in summary, the supply of providers continues to grow, driven by for-profit hospices. The number of hospice users increased. Length of stay among decedents grew. Access to capital appears adequate. The 2009 margin is 7.1 percent, and the projected 2012 margin is 5.1 percent.

So based on that, the Chairman's draft recommendation reads: The Congress should update the payment rates for hospice for 2013 by 0.5 percent.

In terms of the implications, this would decrease spending relative to current law. We would not expect an adverse impact on beneficiaries nor an adverse impact on

providers' willingness and ability to serve them.

So with that, I will conclude my presentation, and I look forward to your discussion and any questions.

MR. HACKBARTH: Thanks, Kim.

You mentioned that one of the candidates for a quality measure was staff contact hours. Are those data collected currently?

MS. NEUMAN: We have information on the claims starting in 2010 on the visit time by nurses, aides, social workers, and therapy. So it is available in 2010, and that was a measure that the folks that we talked with thought was a possible quality indicators.

MR. HACKBARTH: Yes, that sounds attractive and interesting. Have we had a chance to look at how the staff contact hours vary for, say, hospice patients in nursing homes or for long-stay patients? Has that analysis been done?

MS. NEUMAN: So we previously have looked at this when we just had the data on the number of visits, and now we have the data that has the duration information, and we're in the middle of that analysis. So we will have something to tell you on that later, but it's not completed

yet.

MR. HACKBARTH: Okay. Scott, let's begin with you. Any clarifying questions?

MR. ARMSTRONG: Just maybe a general question. It's good news that the percent of Medicare decedents using hospice is going up. But is there any consideration of what we think would be a goal to achieve with respect to that number?

MS. NEUMAN: It's hard to say because so much of what drives hospice enrollment is patient preference. What I can tell you is that, you know, when we talk to people who work in the field, there's sort of a limit, an upper limit on what that number would hit, you know, due to unexpected deaths and other things of that sort. I mean, the numbers I hear people throwing around are 60, 70 percent, but, again, that's all kind of guesswork.

MR. ARMSTRONG: Okay.

DR. CHERNEW: Well, first, I just wanted to say something in response to what Scott just said, which is it's not clear that there's a goal as to how many should have hospice as much as who should have it and when. So you could have a lot of people, but they're getting in too late.

You could have, you know, too many people so it makes it so hard. But I'll save that for round two.

My question is: You mentioned several times that you calculate the margins assuming that the cap -- the amount over the cap is repaid. I didn't see this in the chapter at all. Is there any evidence that the cap isn't repaid?

MS. NEUMAN: Well, it's a little complicated because -- you know, I think it's detailed in the chapter more. There have been some lawsuits and so forth. So some of the cap demand letters have been delayed, and so, you know, sort of the process isn't all the way completed for some of these. For example, in 2009 not all the letters have been issued yet for some of the providers. That said, you know, we know that sometimes some of these providers wind up going bankrupt. It's not a high share, but we do see that happening. So it's not likely that 100 percent will be repaid. I can't tell you how much below, but in general, for those that remain in the market, we expect them to be repaid.

MS. BEHROOZI: I'm trying to find this, and it probably is in here somewhere. You show that the average

length of stay for decedents has gone up, and you note that above-cap hospices have higher than average rates of live discharges. Overall, is there an increasing rate of live discharges? Do we know that?

MS. NEUMAN: We have that information. It's in the chapter. It's broken out by cap/non-cap. The overall number is not there, and I feel like the numbers are pretty comparable to last year. I think I'll go back in for January and give you a definitive answer. I know there is not a big change, but whether there's a slight change in one direction or the other, I should take a look.

MR. BUTLER: First question. On our summary sheet of the rates that we get, it says a 1-percent update is the recommendation, and I'm just curious how that -- is that just an error? Because you are recommending 0.5.

MR. HACKBARTH: [off microphone].

MR. BUTLER: Far right-hand -- oh, I see. I'm sorry. The one -- I got you. Okay.

A couple questions now about capital and cost. Remind me what hospice organizations submit in terms of cost report kinds of information that we use to calculate bottom-line margin and things like that.

MS. NEUMAN: Okay. So they all submit cost reports, and on that cost report is information about the total costs of care across all their patients and the share of patients that are Medicare versus non, and then certain kinds of cost categories, you know --

MR. BUTLER: Depreciation and things like that?

MS. NEUMAN: Yeah. It's sort of a standard cost -- it's a standard cost report. The only difference is really that we don't have revenue information on the hospice cost reports like in other sectors.

MR. BUTLER: What I was getting at is when you say it's not a capital-intensive service, so to speak, compared to some others -- this is more of a comment now. It would be interesting to look at depreciation by each of the segments that we review. And I mention that because if, in fact, you have a lot of capital and a lot of depreciation, you're not likely to be able to replace that at the cost that you purchased it for. Therefore, you need a different kind of margin than you do in a sector that has no depreciation.

So I think as we look at margins, we should think more clearly about home care or hospice or ones that don't

really need capital, and, therefore, they shouldn't need the same kinds of margins in general that, say, LTCHs or SNFs or hospitals -- and I think we treat margins as if they're all alike, and they're not.

Now, I know hospices have often invested in inpatient units, so they are a little different from home care, so they do have some capital needs. But it would be kind of interesting to line up depreciation as a percentage of expenses by each of these sectors and kind of say, well, how -- we make these kind of general statements. We could be pretty specific and quantify those.

MR. HACKBARTH: Thanks.

DR. NAYLOR: So, Kim, do you have a sense of when -- because I know there has been, as your report indicates, movement in NQF on endorsing new palliative care measures. Do you have a sense of when that's going to happen? And, more importantly, how might that play in terms of some of the recommendations we would make to strengthen the overview or oversight of quality?

MS. NEUMAN: So the NQF process is kind of in the midstream right now. They have their -- their draft report I think is out for comment, and I think that has been

completed, and now they're in the voting process. And I think that by February 2010 [sic] they'll have endorsed additional measures. And then I think that sort of, you know, as part of the CMS process, I think they've signaled their continued interest in adding quality measures over time, and so I think we'll see how that plays out, and we'll have an opportunity to comment and so forth in that situation. And then also there's, you know, sort of questions about the Commission's views on pay for reporting versus pay for performance and how you want to move there.

DR. NAYLOR: And one last question. Are we also tracking the numbers of people who are spending their last 30 days in intensive care units in hospitals as proxy for --

MS. NEUMAN: I have not looked at that, but it's something we could look at.

DR. NAYLOR: It's often a population -- not always but often is a population that die that we really should think about if we are able to effect change in that group, it may be a really good sign about getting the right people at the right -- I don't know.

MR. HACKBARTH: It's an interesting idea. Are those data available? Do we know systematically which

patients are in intensive care?

MS. NEUMAN: Can we see it on the hospital claims? I'm looking at our hospital folks. Yeah, so if we can see it on the hospital claims, we can cross the hospital claims with the denominator --

MR. HACKBARTH: Okay. It is on the hospital claims.

MR. PETTENGILL: You can track that [off microphone].

MR. HACKBARTH: Okay, good. That's a good idea.

DR. BAICKER: I thought it was interesting to look at the diagnoses of the population and how the length of stay varied by that, and it made sense that there were some good medical reasons that diseases with more uncertain trajectories might result in more variable lengths of stay. And then you also mentioned that the length of stay, even conditional on disease, seemed to be higher in the high length of stay places. And I thought it would be interesting to know how much of the tail of high length of stay could be accounted for by them selecting different patients. You know, is it that they have -- we feel differently about it if it's that they're selecting the non-

cancer diagnoses, patients, and, you know, they're just getting draws where people end up staying longer versus really that's not -- and from what you've said, it sounds like that's not it. But it would be interesting to partial out the disease mix and be left with how much of it is really just longer length of stay, even conditional on disease mix.

DR. BERENSON: Kim, could you go to Slide 8? I just want to understand the tactics around the cap. The cap is the average payment -- is the cap on the average payment per hospice? Is that what it is?

MS. NEUMAN: So the cap -- it's effectively a cap on the average payment per patient. How it works mechanically is there's this cap amount, which is about $23,000, and each hospice takes the total number of patients for a year, and there's technical details about how that's calculated that I'm going to spare you. But there's the total patients times the cap amount, and they compare that to how much the hospice was paid in that year. And if they were paid more than that, they have to give that excess back. That's how it works.

DR. BERENSON: So, if I have that right, then that

third bullet, substantially more patients discharged alive could actually be a strategy to try to keep your average down and not exceed the cap by more -- is that basically right? So a strategy of having people who may not need to be in hospice, some staying very long and others getting discharged, would be -- they're compatible approaches.

MS. NEUMAN: Yeah

DR. BERENSON: Okay. So that is right. I found -- I mean, yesterday we were throwing around adjectives. Scott had "spectacular." I find it "stunning," I guess would be my adjective, that 44 percent in these above-cap hospices discharged patients from the hospice. I mean, it's just unimaginable in my view that that's what they're doing.

Do we know anything about the quality of care for those people who are discharged? I'm hearing anecdotally problems that in a sense they're getting abandoned. Their routine providers are saying, oh, you're in hospice, and the hospice may be overdoing pain medication, and what we've got here are patients in Never Never Land once they're discharged. Do you know anything about that?

MS. NEUMAN: You know, I don't have anything more on that besides just anecdotes that you hear. That's pretty

hard to get at in any kind of quantifiable way. I'm just trying to think if there are any quality measures that our panel mentioned that could get at that. I think it would be hard.

DR. BERENSON: Okay. But I mean, even nationally, it's 16 percent, so that's a significant population. I think we should be thinking -- I don't have any obvious measures for you off the top, but I do think we should be thinking about that as we go forward.

MS. NEUMAN: Yes.

DR. BERENSON: Thank you.

DR. MARK MILLER: Kim, when we were making recommendations before and looking at patterns of, you know, utilization, was the discharge alive included in that?

MS. NEUMAN: Can you say more? Sorry.

DR. MARK MILLER: We'll talk.

[Laughter.]

MR. HACKBARTH: So on the issue of hospices over the cap, in the paper, in Table 6 it has the trend information on average payments over the cap per hospice exceeding the cap, and it went from $470 in 2002, then jumped up over $700, and then it fell back down in 2008 and

2009, which struck me as sort of an interesting pattern. Any idea, Kim, what might be going on?

MS. NEUMAN: Yeah, sort of what I hear anecdotally is that providers are more cognizant of the cap and have become better at sort of managing their length of stay to the cap. So we're seeing -- while we're seeing more go over, they're going over by less. And then one point of clarification, those are actually thousands. It's not very clear in the table.

MR. HACKBARTH: Yes. Can we follow the same pattern with discharged alive patients? So if we saw that this number exceeding the cap was falling, while there is an increase in discharged alive, that would not prove but that would be consistent with Bob's hypothesis that that's being used as a strategy for managing around the cap.

MS. NEUMAN: We can look at that and see, you know, what we see there. It's possible.

MR. HACKBARTH: Yes.

MR. KUHN: An additional question about the caps. As I read in the paper, CMS has come up with a new methodology for calculating the cap, and that will begin in 2012. When they put that forward, did they put forward any

impacts in terms of the number of hospices that might migrate to the new methodology? Because if I read right, they can choose one or the other. And with the new methodology, did they have any impacts in terms of what they think in the future the number of hospices that might be breaching the cap? Would it suppress that number? Would we see that number go up? That's kind of what I'm curious about, any kind of forecast.

MS. NEUMAN: They didn't include an impact analysis. We've modeled it, and whether you do better under one formula versus the other depends on the individual circumstances of the hospice. And so if they were able to pick perfectly which one favored them, then, you know, you could imagine the amounts going down a little bit.

We may have some more analysis. We're churning through that. We may have some more analysis that we can bring to you on that later. But I think that it will likely ring cap overpayments down a bit in the aggregate.

DR. HALL: Kim, I thought your presentation was very clear. I appreciate it very much.

Apropos of what Mary was saying, I'd like to look at this business of tradeoffs, ICU versus hospice, as you

put it, in a slightly different pattern. When we were looking at SGR rescission and looking at pay-fors, we said, well, there are certain programs if we eliminate it that would help pay off the debt. So I might say, well, here's $13 billion that's being spent on a million people. We could eliminate the hospice program, and we would save CMS $13 billion a year. And somebody who didn't like that very much would say, But have you thought about what would be the alternative? Those people don't go away. It's not as if they just disappear from the map. It's not like buying accessories when you buy a car.

So is there some way that we could actually look at or model what would have been the cost in the more traditional health care system if hospice didn't exist? Because I bet it's tenfold higher than that. It's context that's important in this. It's a very different area, I think, of consideration from some of the other things we've talked about.

MS. NEUMAN: So we haven't modeled sort of the amount that would have been spent by these patients had they not been in hospice, but there's literature on this, and it's mixed. Whether hospice saves or costs additional money

depends on a number of factors. It depends on how long the patient is in hospice. You know, there's a month or two that seems to overall save money. As you get beyond that, it starts to cost more money, and at a certain point the costs exceed the savings.

It also depends on condition. Patients who have cancer or certain other conditions where if they weren't in hospice they'd be using a lot of acute care, that tends to make savings from hospice more likely. Patients with, you know, Alzheimer's, with debility, things that don't use as much of the acute care, savings are a little bit less.

So it depends on a host of factors, and, you know, sort of the research has been mixed. Some have said that it -- I think it's pretty consistent that it saved for cancer. I think the question becomes on the other diseases. It depends, you know, whether you save or it costs more.

MS. UCCELLO: And do the results of that kind of calculus depend on how the payments vary by the length of stay?

MS. NEUMAN: Sure, definitely. If you change the payment system, that calculus could change.

MS. UCCELLO: And can you remind me, you mentioned

at the beginning that there's something in the works regarding changing how the payments vary by the length of stay.

MS. NEUMAN: So the Commission recommended that the payments be increased at the beginning and at the end of the episode near the time of the patients death and to be lower in the middle so it more reflects the service intensity that occurs in hospice care.

Now, the Secretary has the authority, starting in 2014, to change the payment system if she determines it's appropriate, but she has complete discretion over how to change it and if to change it. So it's unclear how that's all going to go.

MR. GEORGE MILLER: Yes, again, I want to echo it was a very good presentation, and the information was very helpful in the chapter.

I want to go back to the cap overpayment because I was struck by the fact that many of the for-profits -- I think Slide 8 mentioned the for-profits almost entirely, and then Bob's very cogent point about the increase in discharge alive. Do we know if there's a penalty for not repaying? And what is the methodology for the repayment? I heard you

say they sent out letters, so what happens if a hospice provider doesn't repay and still stays in business? And, again, we're going back to Bob's point. It seems like the strategy would be to discharge more live patients.

And the third part of my question, if I haven't complicated it enough, do we know if the majority of those are tied into nursing home patients that have been discharged alive as well?

MS. NEUMAN: Okay. I think the first question about sort of the process for the repayment and so forth I'll need to get back to you on. I'll need to find out how that works mechanically.

MR. GEORGE MILLER: And if there's penalty for not repaying it or it could more advantageous not to pay it or delay payment because there's no interest paid or penalty for not repaying it?

MS. NEUMAN: I feel like it's subject to the same rules as other kinds of repayments, but I need to get details on that.

Then the second part?

MR. GEORGE MILLER: Do we know if the majority of those cap payments are tied into nursing home patients as

well and if there's a pattern, especially if they're discharged alive in nursing homes?

MS. NEUMAN: The discharged alive rates for nursing homes are actually slightly lower than the average, and on whether they're serving a little bit more nursing home patients, I think it's slightly higher, but it's not substantial.

MR. GEORGE MILLER: Okay. Thank you.

DR. STUART: I think the tenor of many of these questions boils down to the question of what is the business model that is consistent with these findings, and, you know, we're kind of struggling around that. And it strikes me that there are any number of possibilities. The thing that I find most interesting here is not just the high average margin but the huge variability that you describe around that margin, because if these are for-profit firms, variability is a huge issue. I mean, if the risk is I'm going to make 19 percent or I'm going to lose 19 percent, you know, that's major. So I have one suggestion and then a question.

The suggestion is on page 12, and the way I read this chart is that if you go down to the -- except for that

last panel, the Medicare margins from 7.1 percent then down to 6.2 percent, these margins do not exclude the cap overpay. Is that correct?

MS. NEUMAN: These margins take the total amount Medicare paid and subtract the cap overpayments. It assumes the overpayments are fully repaid to the government.

DR. MARK MILLER: [off microphone] So 7 percent assumes --

DR. STUART: Well, now wait. Maybe I'm misinterpreting that. If I look at that line below cap, it says that the average margin is 7.6 percent. So if I go up to all, it's 7.1 percent. So that suggests to me that the cap repayment has been subtracted from the margins for everything above that line.

MS. NEUMAN: So that 7.1 percent overall margin is a combination of a 7.6 percent margin for below cap and a 1.3 percent margin for above cap.

DR. STUART: Right.

MS. NEUMAN: Which assumes that they've paid the overpayments back, yes.

DR. STUART: Right, right. So I guess what I'm suggesting is that it would be useful to see what those

numbers would be if we assume that the cap repayments have been made for everybody. And the reason I suggest that is that we can't tell from this whether this is strictly a for-profit issue or whether it's for free-standing versus not free-standing.

MS. NEUMAN: It's largely free-standing for-profits. I can show you that in the next presentation. We can give you information to sort of illuminate that.

DR. STUART: Okay. I was just thinking it would be useful to have two columns there under Medicare margin, one that takes account of the cap and the other that doesn't take account of the cap.

Here's the next question. This will go into round two, but I want to lay the groundwork for that. That is, one way to think about this is that we have growth and we also have hospices that are going out of business. So there's some movement here. And I'm wondering if we have followed hospices or whether it's even possible to follow hospices over time to see whether they have startup losses in the first year and then they become profitable or maybe they are very profitable and they pull out their money. You're not going to be able to see this. They go bankrupt

and they don't repay. I mean, there are a number of different kinds of business models that might be consistent with this, and just trying to drill down an see which ones are more probable I think is going to help us in terms of making good policy decisions here.

MS. NEUMAN: We haven't done that, but I think it's possible, maybe not for January but longer run.

MR. HACKBARTH: Kim, among the for-profits, how much of that activity -- how much of the growth in for-profit activity has been through big chains as opposed to through, you know, locally owned? Do we know anything about that?

MS. NEUMAN: I don't have it broken out by chain/non-chain. I think there has been growth in both, but I can't give you a proportion.

MR. HACKBARTH: Okay.

DR. CASTELLANOS: Kim, great job. On this slide, just to point out that hospital is minus 12 percent. Could you go to Slide 14 for a second? You mentioned that the rural nonadjacent was predominantly all hospital, and here I see a 6.5 percent positive. That's a big swing. Any answer for that?

MS. NEUMAN: Yeah, it is a really big swing, and so we've looked at it, and I'm not sure we know what fully accounts for it.

What I can tell you is that hospital-based hospices in rural nonadjacent areas tend to have somewhat more longer stays, somewhat fewer shorter stays, less inpatient care, inpatient hospice care, and a little bit more reliance on nursing homes. All of those factors are associated with higher profitability. Whether it explains that big a swing, though, is really a question. And so, you know, we'll keep looking at it.

DR. CASTELLANOS: And the second question, just more of a clarification. I think Mary brought it up and Glenn asked, too, about the quality issues. You talked about the staff contact hours. The one I was interested in is the pain relief within 48 hours. Can you just clarify that, where we stand and what that means?

MS. NEUMAN: Okay. So that is an NQF-endorsed quality measure that CMS has adopted for the quality reporting in 2013, and the measure is specifically looking at patients who report pain -- or, sorry, report being uncomfortable at admission due to pain, whether within 48

hours they report being comfortable. And so that measure will be a measure that they report starting in 2013, and it's a measure that is relatively common among hospices. It's one they're more familiar with.

DR. CASTELLANOS: Okay. No preliminary data or anything like that yet?

MS. NEUMAN: No. There's no publicly available data on that at this time.

DR. CASTELLANOS: Thank you.

MR. GRADISON: In interest of full disclosure, I was one of the ring leaders that got this benefit written into Medicare law, something over 25 years ago. The others were Bob Dole and the late John Heinz in the Senate and Leon Panetta in the House.

At that time there were questions being raised about the cost, and I will never, so long as I am alert and alive, forget the day that the folks came up from OMB to try to talk make out of it. We wanted to see all their numbers and their calculations. You may have heard me refer to this before because it's really well engraved in my head. And as they were getting down to their numbers, rather than using the term "beneficiaries" or "patient" or whatever, they used

the term "units of production" to refer to the numbers they were multiplying out. That's the God's truth, and I will never forget it, and you can see why.

I'm not suggesting my interest exceeds that of anyone around the table, but I just have a particular concern that we be on the side of the angels in making sure that this program operates successfully. And I am concerned about the serious allegations that relate to nursing homes and, therefore, I want to address that with a few questions. I think I know the answer, but I just want to make sure.

Does the Secretary have the authority to implement the OIG recommendations?

MS. NEUMAN: Yes, in 2014 or later.

MR. GRADISON: Okay. I want to drill in a little bit on something which I recall from the initial legislation, which was the 80-20 rule. The general idea was to discourage institutional care and to balance this heavily towards home care by requiring that 80 percent of the days be in the home setting. I forget whether the nursing homes were included in the 20. I know hospitals were, of course, but could you enlighten me on that, please?

MS. NEUMAN: Sure. So the rule you're referring

to is that no more than 20 percent of the days can be billed at the general inpatient care level, which that's care that is for managing symptoms that are acute, short-term care that cannot be managed in a home-like setting. And so that level of care would be in a hospital or a nursing home.

However, most of the nursing home care in hospice that you see is at the routine home care level. It's people who are residents of the nursing homes and are getting hospice care like someone would be getting it in their home in the community.

MR. GRADISON: So that's divided, but depending upon the degree of severity of the -- the condition of the particular patient. It's not whether they're in a nursing home or not. It's whether they need a level of care that would be included in the 20 percent.

MS. NEUMAN: Right, crisis management, that higher level of care paid at about $600 a day compared to home care, which is more like $150.

MR. GRADISON: One final question. Is there anything that we should consider doing beyond these recommendations that would be helpful in addressing some of the allegations that have been made -- and I stress the word

"allegations" -- in the nursing home area?

DR. MARK MILLER: Actually, I wanted to follow up because you had asked this question. When Bill asked the question does the Secretary have the -- and I'm going to answer your question. When he asked the question does the Secretary have the authority to implement the Inspector General's recommendations, that includes -- and you said yes, after 2014. That includes this most recent one where they said you should change the rate in the nursing home?

MS. NEUMAN: Yeah, in 2014, the Secretary has complete leeway to revise the payment system.

DR. MARK MILLER: Okay, and it makes sense to me, but I hadn't actually thought it through to that last point.

So one thing that we did when we were -- we had raised this issue a few years back. We had asked the Inspector General to look into it because we had seen patterns in the data but we couldn't quite get into the relationships and agreements that exist. The IG -- and you will have the facts better than me -- came along and made a recommendation and said the rate in nursing homes should be adjusted because of this incentive situation. Included in the SGR letter that we put out in October was a proposal to

make an adjustment to the nursing rate that was a 3-percent adjustment, if I remember correctly, but it also said you had to have a certain amount of volume in the nursing home, because the assumption is the more you do that, the more benefit you get. And it was sort of a place holder in trying to operationalize the IG's recommendation. So you were asking about steps that we could take on the nursing home. That's at least one that we've put on the table.

MR. GRADISON: Should we repeat it then as part of this package?

DR. MARK MILLER: It's certainly a possibility.

MR. GRADISON: Thank you.

MR. HACKBARTH: So looking at the relationship between staff contact hours for the hospice and nursing home residents would be an interesting thing to look at.

MS. NEUMAN: That is possible to do.

MR. GRADISON: I have actually been struck in an individual case -- I know this is anecdotal, but it involves family -- where the patient is in hospice, is in a nursing home, but on many occasions, for a variety of reasons, the people from the hospice come into the nursing home, sometimes on very short notice and sometimes on a more

routine basis, particularly because of some severe respiratory problems. And I'm a layman, but that seems to me to be the way it's supposed to work. I'm not talking about the dollars and cents, but in terms of the case.

MR. HACKBARTH: I'm just wondering whether when a patient is a nursing home resident and as a result they have more support around them, whether that alters the need for contact from hospice staff. That's the question I'm asking. It seems to me that it might --

MR. GRADISON: Oh, yes.

MR. HACKBARTH: -- reasonably, as opposed to a patient who's living at home, and so it would be interesting to explore that.

MS. NEUMAN: Yeah, and the OIG noted in that report that there's overlap in the aide services that a hospice is paid to provide and a nursing home is paid to provide.

MR. HACKBARTH: Right, exactly.

DR. BORMAN: I don't have any clarifying questions.

MR. HACKBARTH: Scott, round two comments, including on the draft recommendation.

MR. ARMSTRONG: So, first, just generally, I would echo comments made by several others that I think our investment in hospice services is an incredible value for our beneficiaries, and this seems to be, notwithstanding some of the issues that were just raised about programs hitting the caps and long lengths of stay, a program that is in reasonably good shape, I thought Peter's point was really great. It was on my mind, too. How do we judge whether the margins in any sector are appropriate or not? Because there is so much variation around that. It seems to me that the kind of margins between 5 and 7 percent, with a lot of variability that we're talking about in this sector, doesn't seem so unreasonable relative to some of the other sectors. Yet, on the other hand, it is a low capital-intensive sector, relatively. So, anyway, it ends up leaving me thinking I guess the recommendation seems about right. Zero would have seemed about right to me, too.

Then my final point would be a lot of this conversation we were having really does relate to some of these quality measures, and it's too bad we haven't been pushing for those for an earlier implementation. But so much of this question about why are patients in this program

for more than six months seems to me to have to do with how well are we measuring the criteria by which patients are admitted to the program rather than how well are we protecting the cost at the back end to Medicare for patients that exceeded that length of stay. And it just seems to me there are some patients who appropriately will exceed the timeline and that they were a very appropriate patient to be in the hospice program, and some who shouldn't have been admitted to begin with. And I hope that our quality measures as we go forward will help us to feel confident that that decisionmaking process is really getting the scrutiny that it should.

DR. CHERNEW: So I agree with that, and I just wanted to say I support the recommendation, and I'll say a few things.

The first one is I think it's important to remember, particularly in this case, that the goal of all we do isn't just to save money. There's a lot of things we could do to just save money. The goal is to provide access to high-quality care, and certainly hospice can be a part of that. And it's tempting to try and only want to use hospice when it saves money elsewhere. And certainly we would want

to use hospice when it saves money elsewhere, but we'd probably want to use it where it improves quality even if it doesn't.

For that reason, I think the quality measures are crucial, and this is sort of a surrealistic place. It's the only place I know of where higher mortality is almost a measure of success, which is sort of odd. And when you look at issues like staff contact, we can't tell if it's a quality measure or a measure of inefficiency in various ways because the product is so amorphous in various ways. And so coming up with quality measures is central.

I think that Bill was on the exact right track, which our basic problem is -- and I've been ranting against this periodically over the past few years, this sort of general fragmentation, and nowhere is the fragmentation to me more problematic than here, because this is really not about how hospice is doing or how hospice is not doing. It's really about how the process of care for these beneficiaries is being managed over the course of this period in their life cycle. And sometimes that's hospice, and they can add a lot even if the patient doesn't die. And sometimes it's not hospice even if the patient does die.

And we can't -- so, you know, what Scott said I think is exactly right. What we really need to know is what set of services they need and when they need them, and that is exceedingly hard to do. But I think our basic notion of the structure, we want to have quality measures for hospice, and then later we want to have quality measures for nursing homes, and then we'll want to have quality measures for home health or all these other ones, isn't really the right way of thinking about it. We want to have quality measures for a group of patients in a particular clinical case, and we want to hold some entity accountable for that care, be it that they've brought in hospice or that they didn't bring in hospice or that they discharged someone too early or too late.

And so I'm very supportive of this because, you know, baby steps, but I think as we move away from our March type report to our June type report, the type of things we really need is broader measures for how certain patient populations are to be cared for independent of what organizations are caring for them, because hospice I think is a tool more so than some sort of stand-alone thing. And trying to sort of medicalize it like it's a cancer treatment

or something isn't really the right way to think about it, in my opinion.

MR. HACKBARTH: I agree with everything you said. You know, we often fixate on how, when we have these different payment silos, that that fragments financial accountability. And what I hear you saying is the other side of that is that clinical accountability, responsibility for the welfare of the patient is also fragmented by these silos, and that gets in the way of our doing really sensible measures of clinical performance.

DR. CHERNEW: Right, so if I had my druthers, which I don't, I would have patients that are in nursing homes, have the nursing home accountable for that patient for their whole spectrum of care. And if hiring an outside hospice agency to come in to improve that process improves that process, I think that would be great. But having a separate set of sort of hospice quality measures and then nursing home quality measures that may conflict strikes me as a little cumbersome and missing the patient centric-ness of the whole exercise.

MS. BEHROOZI: First on the recommendation, I agree with Scott about the number. You know, 0.5 is okay,

zero would be okay, too. The margins seem to be able to withstand that. And, you know, what Peter said about the relative need for capital investment and things like that.

I want to focus on my little red wagon. I really appreciate, Kim, that you went into depth in the paper about the volunteer requirement. And it's basically three decades old, and it relates to a time when this was -- and I wish Bill were here because I want to say this not only with all due respect, but I'd love to get his feedback. We can talk about that later -- about what was intended at the time that the benefit was crafted and the requirement was implemented. And you said that the statute requires that hospices keep records of use of volunteers, including documenting the resulting cost savings and service expansions.

Now, we don't have the data back to 1983, but in 2000, for-profit hospices were -- there were 766 of them, and not-for-profit and government were about 1,500, so there were about half as many for-profit as not-for-profit and government. And ten years later, in 2010, there were almost 2,000 for-profit and about 1,500 not-for-profit and government. So the balance is significantly shifting, and the percent change, the growth, is really all on the for-

profit side.

I don't think that's what they had in mind. I mean, you know, what for-profit company is documenting the savings achieved by using volunteers? I don't think that's the business model, as Bruce was saying, that was contemplated when a requirement to use volunteers was put into the statute. And it becomes of greater concern, I think, when you talk about how the facilities that are documenting what their volunteers are doing would be unlikely to furnish those same services with paid staff, and that these services result in higher satisfaction by families, including using volunteers to sit vigil with patients who do not have family in the last hours or days of life so that those patients don't die alone. Isn't that what palliative care is supposed to be? What are these for-profit providers or any of the providers doing if that's not what they think they need to use their Medicare payment for?

So I get it that when you're talking about financially strapped, community-based or, you know, mission-driven, religiously based organizations that add hospice services to the other types of services that they provide, that having volunteers available means they can expand their

services, and I understand some of the thinking that was going on three decades ago.

Now when we see business models that, arguably, possibly, are dumping patients in order to avoid the cap -- and it's all a financial calculation -- I think it's unconscionable that they are, quote, required to have 5 percent of their costs off-loaded onto volunteers. I don't think that comports with labor law in this country. I don't think that comports with basic notions of how business is supposed to work, how you're supposed to support yourself.

So what I'd like to suggest is that, whether it's during my last meeting in my term or at some point, MedPAC actually recommend to Congress that that requirement be eliminated.

MR. HACKBARTH: Bill, I'd like to get your reaction to this if you feel comfortable. To sum up, Mitra was saying that the volunteer requirement in the original statute may have made sense in the context of what was then an almost entirely, if not entirely not-for-profit business. It doesn't make as much sense when virtually all of the growth now is on the for-profit side. And so she, as you just heard, is saying she thinks that maybe has outlived its

usefulness and ought to be repealed. Do you have any reaction to that? And if you want to think about it, that's fine.

MR. GRADISON: I really would like to think about it. It's far from clear to me that that's inconsistent with running a for-profit organization. I'd like to give some more thought to it, but I'm not trying to delay response, if I understood you correctly. We can talk about that separately.

MR. HACKBARTH: Sure.

MR. GRADISON: And perhaps some more thought could be given to the appropriate -- it is absolutely true that when we started down this road, there were no examples that I can recall of for-profit hospices here or abroad. Basically the hospice idea was imported from Britain. It took root in Connecticut, as you may know. The attempt was to follow that model and to have restrictions, like the 80-20 rule and so forth, and this, which are consistent with that model. Probably the broader way, which would be inclusive of this issue, is to take a look and see what is the significance of the for-profit versus not-for-profit model in this particular program. I'm not saying that to

suggest anything's wrong with for-profit operations, but what is the implication of that as measured against the original limitations -- which were quite intentionally imposed to try to preserve a certain model, and the role of volunteers -- I'm sure I'm not the only one around the table who has actually talked to some of these volunteers and visited some of these institutions. These are some of the most remarkable people I've ever met.

I'll never forget one lady I met at a place I had gone back to from time to time, and I had seen her there before, and I said, "How are you?" And I said, "You really look down." She said, "Three of my patients died this weekend." It's a different kind of volunteer than we may normally think of.

MS. BEHROOZI: I just want to clarify. I absolutely appreciate the value of volunteers in all kinds of settings where they can enhance the care that's provided, and particularly in this kind of setting where you might have burnout among professionals and that kind of thing. It's just about the requirement in the statute. I certainly wouldn't want to make it a prohibition for either type of provider, for-profit or not-for-profit. My guess is that

volunteers would gravitate toward not-for-profits, but that's a guess.

DR. DEAN: I can support the recommendation, although I would agree with Mitra and Scott that it could be zero, it could 0.5.

I have a question, and I apologize for being late, and maybe you went over some of this, but particularly the issue of the very short stays, which I think has been a worry or concern all along, and how that ties into the restriction that people have to give up the right to any acute care and whether that requirement does, in fact, lead to more of the really short stays, people reluctant to go into hospice.

And I understood, I think, in the mailing material that there is a demonstration project or an attempt to try to measure if that's, in fact, a barrier to getting people into hospice at an appropriate time. And like I say, if you went over some of this, I apologize. I missed it. But I'm just curious how far along that is and how much progress we've made in that regard.

MS. NEUMAN: So PPACA includes a provision that requires a pilot project of concurrent hospice care with

other conventional care at, I think, 15 sites. My understanding is that that's still under development. There hasn't been any release on that demonstration up to this point.

DR. DEAN: So we really don't know when that might take place.

MS. NEUMAN: Yeah, I think it's a question of when that would take place, yes.

DR. DEAN: And there really hasn't been much change in the proportion of people with really short stays. is that correct?

MS. NEUMAN: That's correct. It has been pretty steady. We had a one-day jump in the median this year from 17 to 18 days, but that's still, you know, very minimal.

DR. DEAN: Thank you.

MR. BUTLER: I can support the recommendation and would comment we obviously have a love-hate relationship with hospice in the sense that we can't imagine a more humane benefit that you want to offer, yet it's not quite what we thought. And I think what gnaws at us is the -- I don't think anybody quite envisioned the for-profit growth and the kind of thought out of making money off of people

who are dying just doesn't -- or even looking at earnings per share, it just doesn't seem like it's somehow the model that works. Yet, nevertheless, for-profit organizations can provide a lot of fiscal discipline in most of the services that Medicare provides, so it's the model we have.

What strikes me, though, is that while we spend a lot -- and this is the patient-centric concept that I think Mike was talking about. We spend a lot of time on episodes of care for acute illness. We almost need like episodes of death. And while we've understood better and documented the growth of the neurological applications, the palliative care in general, and things beyond cancer, I'm not sure we've quite mapped out well enough the pass, and, therefore, the mix of services that ought to be provided. I know that's undoubtedly beyond the staff's capability to do that, but I think it would provide greater clarity if we looked at a patient centric, here's the diagnosis, here's the outlook, and there would be major categories that you could help better explain where you ought to be in what setting with what range of services.

DR. NAYLOR: I fully support the recommendation, and I fully support all my fellow Commissioners' comments

about the need for a more robust understanding of what happens to people during their last year of life so that we can really figure out how best to match services and needs, and that is well beyond it. But I do think that their direction in both getting the NQF-endorsed measures used as quickly as possible once we can, you know, if we think that they really add to our understanding of what is happening to this population is a really good thing.

I also think that the direction of MedPAC in terms of understanding that people, when they enter hospice as a benefit, really have an unbelievable set of needs that need to be focused on initially and then at end of life. So that direction in payment I think will help us dramatically if we can move along those lines.

I think the issues around short stays are really as important as those that stay alive, and that's the whole notion of getting a perspective much more broadly. We are being called upon to deliver transitional care to people who are leaving hospice because they're alive, because they go to nothing. So I think both ends of this suggest that we have real needs, and I'm not always sure -- I think, you know, we are imprecise in decisionmaking, even the best

diagnosticians, about the six months. And so some delay making the determination because they really don't know, and that's why we end up with 17- and 18-day lengths of stay. And really excellent palliative care has a positive impact on some people, and that's why they survive beyond six months, because we haven't been giving that kind of care delivery to them for a longer period of time.

So I really think this is moving in the right direction, but I totally agree with earlier comments that this is a part of a process that needs us to really look at people over time.

DR. BAICKER: I support the recommendation, and I think the point about developing better quality measures is really well taken, both because of gauging quality in and of itself, but also because we care not just about the total utilization of hospice, but as people were saying before, the composition and the targeting to the right patients. And I suspect that some of the quality measures will also give us better information about whether hospice is reaching the right patients at the right time as well.

DR. BERENSON: We always have the problem of deciding on what the single update should be when there's a

variation, and usually there's lots of different factors in play, and we just have to make a judgment here. As opposed to almost all the other sectors, the sort of stark difference between the for-profit and not-for-profit seems pretty clear. And so looking at whether it should be zero or 0.5, I guess I'm persuaded that it should be 0.5, looking at trying to support the nonprofits, looking at their last eight years, they've always -- their margins have between 0 and 2 percent. This year they were higher, and if they consistently get up a little higher, then I might view it.

So I want to support the nonprofits, and we have other strategies that hopefully will be successful related to a new payment model that we've recommend investigation. Just a lot of things to figure out what's going on with the other part of this sector. So I would support the recommendation and argue for the 0.5 even though I understand the argument for zero as well.

MR. ARMSTRONG: I, too, support the recommendation as put forward. I also am very pleased and very supportive of the re-running of past recommendations, and I like the fact that they're up front in the chapter, and I think that's a good lead-in to the conversation on this issue. I

think it's very helpful.

DR. HALL: I'm also supportive, and I think one of the important things we're doing here today with this by looking at the variability in margins and trying to do something about it is that while hospice has gained a great deal of traction in American medicine, it's by no means a slam-dunk that it will continue and continue to evolve in the way that it has to. And I think one of the greatest contributions we can make now is to clean up obvious criticisms of people who don't see it that way, and certainly variability in margins is very high on the list. So I think we're making a great blow for justice here, speaking as one, Bill, of 17 units of production on MedPAC.

[Laughter.]

MS. UCCELLO: Everything that I was going to say has been said, so I will just say that I support the recommendation.

MR. GEORGE MILLER: Thank you, and again I'll echo many of the things. I do want to bring up a couple points because I do want to support, like Bob said, the not-for-profits. But there is some concern, at least in my mind, with -- I think one of the responsibilities of this

Commission is to protect Medicare beneficiaries and provide excellent clinical quality and make those recommendations. And then when you see the wide variation in margins for the for-profit business, it raises some concern and some issues. Particularly the issues we've talked about with early discharges, with the cap payments, and nursing home payments, it raises some concern. But Bob quite eloquently convinced me that also the struggles with the not-for-profit -- I will support the 0.5, but I do want to raise the concern.

And then Peter articulated very clearly the fact that if we look at depreciation and margin together, we may have a different picture versus just looking at the margin. The capital intensiveness of one sector like a hospital versus nursing home or -- I'm sorry, hospice or home care is completely different. You have to have standby capacity, bricks and mortar and equipment. And then for entities like hospitals and others who have a myriad of regulations that they have to deal with changes the complexion a little bit from my perspective.

So a long story to say that I could support the 0.5, but certainly we need to look at depreciation and other

issues versus just purely looking at the margin.

And, finally, I think Ron brought up a very good point earlier that we saw the rural not-for-profit hospital-based having a pretty good margin, and that's with the allocation of overhead, and they were apparently doing something right. So I'd love to hear what they were doing right and still had a reasonably healthy -- nonadjacent, rural nonadjacent. So I'll support the recommendation for 0.5 because of the work and the not-for-profits, and I've talked with some of them who struggle, particularly in areas -- and Mitra's point about the volunteer part of that is just right on the mark.

DR. STUART: I'll come to the recommendation in a moment, but I think that there is such a significant consensus among the Commissioners about the difficulty in looking at each of these post-acute -- maybe it goes beyond post-acute -- services independently because we know that, in fact, they are or should be better coordinated. And so I guess the point I'd like to make is it would be helpful if that could be reflected in this chapter.

Now, I know what Glenn is going to say. You know, we are forced by the Congress to look at each of these silos

independently, and, you know, so we'll do it and we'll come to this. But, you know, I really think that from this point onward it would be helpful, to the extent that we have this consensus, to make that point in each of these chapters. You know, maybe somebody upstairs will finally get the point.

MR. HACKBARTH: Let me be predictable in the first thing I say. Yeah, we are required to address them sector by sector. That's what the Congress asked us to do, and, of course, we will do that.

Having said that, one thing that we've done in the past is, as a prelude to all of the post-acute chapters, have a section -- I think sometimes it has even been a free-standing sort of chapter -- talking about the issues in post-acute care more broadly and expressing the need to think about this as a whole as opposed to individual pieces. So, you know, we can certainly do that again. There's ample precedent for that.

And there is, in fact, important work that has been underway at our urging to try to develop common patient assessment tools and classification tools that would support ultimately moving towards a much more coordinated approach

to post-acute care services. In fact, you know, at some point that's something we ought to -- the status of that work is something we ought to hear a report on.

DR. STUART: I guess my recommendation here is that we start with this chapter and then move forward in terms of what's necessary to make that a stronger case than I think we've made in the past.

Let me come to this recommendation, and actually I'm uncomfortable with this recommendation, and the reason that I'm uncomfortable with it gets back to this question that we've been talking about, for-profit and not-for-profit, and I think that misses the point in the following sense: You know, we live in an environment in which we have for-profit and not-for-profit providers, and I think most of us are comfortable with that. What we're not comfortable with is unethical business practices. And to the extent that we see evidence -- or maybe it's not quite evidence yet, but at least indications that there might be unethical business practice, then the last thing we'd want to do is give them any update at all.

So I guess what I'm struggling with here is: Are there indications of such potentially significant unethical

behavior that we should have some kind of a recommendation that would indicate that? And then, obviously, the update would apply to ethical behavior, and I'm certainly -- I would approve this particular recommendation for them.

Where I come back to the potentially unethical behavior is, first of all, when we're looking at those data on the proportion of hospices that exceed the cap, and when we subtract the cap overpayment, we have an average margin of 1.3 percent. Now, that's not a business model that succeeds. The only way that business model succeeds is if at some point the businesses are taking the money out and then have no intention to pay it back. And you indicated that there were some bankruptcies. Now, I don't know whether that's the case or not, but that's what I see in these numbers.

And then we hear, well, this is 2009, and now the firms are learning, and so they're discharging more long-stay patients alive, and, you know, that's not a business model that's ethical either. I mean, that's a real problematic concern, as Bob raised. And so I wonder where this particular thing is going. I'm not going to be here, but next year when we look at the Medicare margins for 2010

and we find that relatively few firms are above the cap, that might mean no improvement at all. It may mean that they're just passing off these patients who were admitted inappropriately and then finding out what happens to them over time becomes really important.

One of the things that struck me is, well, do we have some of these firms that are passing on their discharges to, you know, other firms that are admitting them and, you know, we go through the whole cycle again?

Now, you know, I have no evidence for anything that these things are actually occurring, but it is troublesome to me when I look at these because it seems possible that that could be the case.

So I support the recommendation, but I think that we really need to spend a little more thinking about what are the potential unethical business practices that may underlie some of these trends.

DR. CASTELLANOS: I support this entirely. I just want to make an observation. I guess this issue on hospice really brings out the value of the Commission and each one of you bringing a separate viewpoint coming from a different background. And that's the real value. And I appreciate

all of you for what you do and your honesty, and all of us really just want to do the right thing.

MR. GRADISON: I support the recommendation. I'd like briefly just to say a word about Peter's very helpful comment about diagnoses and the prognosis.

There are clear-cut diagnoses -- AIDS is the best example -- where the anticipation of high mortality rate changed because treatments were developed. I only cite that to say that even when there is a clear-cut diagnosis, they're not all pancreatic cancer, and as new developments come along, that may over time, because of the advances of medical science, influence the averages.

But in addition to that, there are some diagnoses which I as a layman -- it beats the heck out of me what they mean. "Debility"? That's one on the list. Debility. It reminds me of a comment in Henry Aaron's book. They were taking a look at the British health care system, and they were interviewing some doctors in Britain about why certain treatments were denied people as they got up in years. And this one doctor said, "Everyone over 55 is a little bit crumbly." Which, you know, that I guess is what debility means to me as a layman. And I get a little worried about

whether the definitions themselves don't need to be narrowed so that they are, as you suggest, Peter, more tightly related to a prognosis that makes sense in terms of the six-month objective.

DR. BORMAN: I support the recommendation. I think that every part of the program we're continuously balancing sort of the humanistic view of the individual beneficiary versus the appropriate stewardship of the system, and, rightly, that gives us all pause. This issue I think brings it perhaps to its maximum sort of angst for all of us because we certainly realize the very vulnerable period of life that these patients and their families are in, and it makes it perhaps more challenging for us to step back and try to do our business as appropriate stewards. And I think the discussion has reflected that.

I think that Bill and Peter and Mary and others have alluded to the clinical imprecision here and that the change that can impact the clinical imprecision. I think, though, in previous years the data that you've shown us pretty clearly showed that the increasing length of stay has been linked to an increasing number of patients admitted to hospice with dementia and other neurological conditions.

And that's just a fact, and a fact that we have to deal with. And it's a fact that the prediction of the evolution of those diseases is huge imprecise at our current level of knowledge, and not clear breakthroughs on the horizon to materially change that, at least for a while.

Given that, it also shows up how this really overlaps into that whole issue, as does some of the other parts of the system in some of the SNF discussions we've had, or home health, that really in some ways around the margins of the Medicare program we are, in fact, constructing a long-term care benefit. And the long-term care benefit and end of life and appropriateness are just things that the public in the main finds very difficult to confront. Just as we, as perhaps a cut above in the education about the program, find it difficult to have a meaningful conversation about and arrive at some conclusions, you can imagine that, you know, if you have this conversation with your neighbors, you know how very difficult this is; and if you have this conversation within a crisis situation within your family, how very difficult the conversation is.

But I think that we do have to be honest that part

of what we're struggling with here is that this shift in the beneficiaries seeking hospice is in part somewhat reflective of the absence of an easy long-term care plan for many families. And the Medicare program simply isn't set up to provide that, and it is important that we consider that as politically unpalatable, as distasteful as it may be to us, we do have to acknowledge that that's a factor in this a little bit.

Having said some rather, you know, big-picture things, what in practicality can we do besides this recommendation and continuing to try and drill on the ways that have gone on? I see -- and perhaps Mary in her transition work has seen -- that oftentimes when patients move to hospice, their sort of background primary care system kind of goes away because now -- because hospice in some ways sometimes is so good at what it does and that these things are very difficult for a busy practitioner to keep track of many of them -- and Tom may have thoughts here -- but also that there just tends to be this shift that the patient transitions to hospice and then they're sort of there, and the rest of the medical care world oftentimes is detached from that. And I wonder if there's opportunity to

feed back to the initially referring or co-certifying physician that the patient has been discharged from hospice alive or is now in their second or third or fourth period of hospice, just as a means of growth in our clinical practice if we knew that maybe we would be better invokers or certifiers of patients.

In the background there's certainly a lot of efforts going on in both medical school education and other health professional education to address knowledge deficiencies about palliative care and end-of-life care and so forth, and those hopefully will make a difference in making us better clinically at doing that. But they're going to be a long time playing out, and it's right that we have that parallel structure. But is there some sort of feedback that we could ultimately think about for providers that would make us better in the up-front part of that process, because I think defining criteria more tightly for patients to access hospice, I think it's going to be a losing battle, and I think that probably the impact that we can have is perhaps making the certification up front, be knowledgeable about how long somebody was in hospice. So that's about the only practical thing I have.

I also think that, you know, the point that Mitra raises about the volunteers, as difficult as it is for us to all think about a little bit, is sort of that point of balance between being appropriate stewards and being practical versus sort of the emotional piece that we attach to this. And I think she does raise a very valid point that we need to be thinking about it as we move forward in all this.

MR. HACKBARTH: Okay. Each year when we talk about hospice, it seems to me we spent more time talking about for-profit versus not-for-profit than almost any other sector that we discuss. Peter offered a hypothesis that maybe it's because we're talking about patients who are close to death and very vulnerable, and that may well be the case that we're troubled by, even subconsciously, about people making money and organizing businesses around this particular population.

From my perspective, the issue really isn't so much for-profit versus not-for-profit. In point of fact, there are a lot of people who make money off of dying patients. They're not paid to make them die. They're paid to help them, and for-profit hospices are paid to help dying

patients, just like drug manufacturers and physicians and a whole lot of other participants in the system.

I do think that in sort of the unique circumstances here, where we've had a largely not-for-profit industry and then over a short period of time a rapid influx of for-profit providers, there's a signal there. There's information there. In fact, for me an analogy is how dye is used to enhance an image for a radiologist. Well, in a sense the influx of for-profit providers is sort of a dye in the system, and they're helping us diagnose weaknesses in the payment system. Because of their for-profit motivation, they sort of lead us to where the potential perverse incentives are and the problems are. And I think that has sort of been the journey that the Commission has been on, and we have seen these problems magnified perhaps because of the profit motivation and have offered a series of recommendations now that I think still make sense for how to reform the payment system to at least ameliorate those problems, if not eliminate them.

So I do think we're making progress. I hope that the work on payment reform accelerates, and we have some new ideas from Mitra and others about further recommendations we

might offer.

Thank you, Kim. As always, a good job.

Now let's move on to inpatient rehab facilities.

[Pause.]

MR. HACKBARTH: Christine, you can begin whenever you're ready.

MS. AGUIAR: During this presentation Craig and I will discuss the adequacy of Medicare payments to inpatient rehabilitation facilities, also referred to as IRFs. Craig is here with me because of his expertise with IRFs and with acute-care hospitals.

IRFs provide intensive rehabilitation service. They may be specialized units within an acute-care hospital or a free-standing facility. Medicare fee-for-service is the principal payer for IRF services accounting for about 60 percent of total cases in 2010 and over $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, some of which are listed on the slide. Effective January 2010, CMS revised the coverage criteria and process

and documentation requirements. The revised requirements are more clear about which patients are appropriate to be treated in an IRF, when therapy must begin, and how and when beneficiaries are evaluated, but they are not major changes from the former criteria.

IRFs must also meet the compliance threshold which stipulates that no fewer than 60 percent of all IRF patients have at least one of 13 conditions. Because IRFs are a more costly setting for post-acute care, CMS developed the compliance threshold to ensure that IRFs were treating patients that were appropriate for this setting. After the compliance threshold was renewed in 2004, volume, occupancy rates, and the number of beds declined. However, the industry began to stabilize after 2007.

During this presentation we will focus on recent IRF trends; however, there is more information on the compliance threshold in your mailing materials.

Just as a quick reminder, we use the same framework for payment adequacy as other sectors.

I will now begin with three of our access-to-care measures, and we'll start with supply, which is not included on this slide. In 2010, there were close to 1,180 IRFs, and

between 2009 and 2010, the number of IRFs decreased by 17 facilities. This was the net result of a decrease of 25 hospital-based facilities and a gain of eight free-standing facilities. While changes in supply vary by IRF category, the overall picture suggests that IRF supply is adequate.

The number of rehabilitation beds and occupancy rates, which are presented on this slide, are measures of IRF capacity. In 2010, the number of beds declined by close to 1 percent, which was the net result of a 1.6-percent decrease of hospital-based IRF beds, and a 0.2-percent increase in free-standing IRF beds. Also in 2010, occupancy rates fell by half of a percentage point but still remained above 62 percent. Occupancy rates were higher for free-standing IRFs than for hospital-based IRFs. Overall, both the number of beds and occupancy rates indicate that IRF capacity is adequate to handle current demand and can likely accommodate future increases in demand.

This chart presents fee-for-service spending and volume. IRF volume remained relatively stable in 2010. After increasing by 2 percent in 2009, the number of cases decreased by close to 1 percent in 2010. Fee-for-service spending on IRFs increased in 2010 by close to 5 percent,

and payment per case increased by 3 percent. This is likely due to a 2.25-percent update to the base rates in 2010, a 4.4-percent increase in outlier payments, and a 0.4-percent increase in patient severity.

We also analyzed IRF patient mix, which has changed since 2004 as IRFs adjusted to meet the compliance threshold. As expected, between 2004 and the first six months of 2011, the share of cases with conditions that count towards the compliance threshold increased. However, the share of cases with some conditions that do not count towards the compliance threshold, such as debility and other orthopedic cases, also increased. The share of major joint replacement cases declined, which is to be expected since CMS limited the types of these cases that count towards the compliance threshold in 2004.

We have also seen a shift in the settings of post-acute care for major joint replacement cases. Acute-care hospital discharges to IRFs for these patients declined by 16 percentage points between 2004 and 2010 and increased by 5 and 11 percentage points to skilled nursing facilities and home health agencies, respectively. Finally, as the IRF patient mix has changed, the average patient severity has

also increased.

Quality of care is another one of our measures of payment adequacy. For the past few years, we did not have risk-adjusted quality measures for IRFs, and this year we worked with researchers at RAND to develop risk adjustment models. More information on the methodology of the risk adjustment models is included in your mailing materials, and I'm happy to answer any questions you have about the methodology.

This table shows the preliminary risk-adjusted results across all IRFs for the five quality indicators. As you can see, there was an incremental improvement in quality between 2004 and 2009 across all measures. In addition, while there are high rates of discharge to the community, as you can see in the last two columns on the table, more than 10 percent of IRF patients that were initially discharged home were readmitted to the hospital or admitted to a SNF within 30 days after discharge. This represents an area for improvement in the quality of care provided by IRFs.

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

yesterday's hospital presentation, hospitals' access to capital appears adequate.

To measure access to capital for free-standing facilities, we reviewed access to the credit market for one major national chain. Although the cost of accessing both the debt and equity markets increased for this chain in 2011, the chain is able to access the capital markets because of positive revenue growth.

I will now move on to the measures of Medicare payments and providers' costs.

This chart shows the Medicare margins for IRFs. Between 2009 and 2010, margins increased from 8.4 to 8.8 percent. On this table we can also see the relationship between volume and margins. Margins increase as bed size increases, and facilities with more than 22 beds have positive margins, while facilities with fewer than 21 beds have negative margins.

We can also see that margins vary substantially between free-standing and hospital-based IRFs. Free-standing IRFs, which account for almost 42 percent of total IRF spending, have over 41 percent margins in 2010. In comparison, hospital-based IRFs, which account for 58

percent of total spending, had negative 0.2 margins -- I'm sorry, negative margins of 0.2 percent.

On the next slide I will discuss some possible reasons for the differences in margins between hospital-based and free-standing IRFs.

As context for this discussion, note that hospital-based IRFs are not acute hospitals' primary line of business. In addition, hospital-based IRFs constitute 80 percent of all IRF facilities. However, they account for a smaller share of Medicare discharges, specifically 58 percent. Therefore, 42 percent of Medicare IRF discharges are in free-standing facilities that have an average of 21-percent margins.

It is likely that hospital-based IRFs have lower margins than free-standing IRFs because they tend to have lower volume, lower occupancy rates, and, therefore, have higher costs. As we saw in the previous slide, margins for IRFs with fewer than 21 beds are negative, and more than half of hospital-based IRFs have less than 21 beds. As we saw in Slide 4, hospital-based IRFs have lower occupancy rates than free-standing IRFs.

Further, hospital-based IRFs have higher costs

than free-standing IRFs. Direct costs per case are 30 percent higher in hospital-based IRFs, and indirect costs per case are 11 percent higher. Total costs per case adjusted for wages, case mix, and outlier payments are 34 percent higher in hospital-based IRFs than in free-standing IRFs.

Although Medicare margins for hospital-based IRFs are close to zero, on average the IRF units are able to cover their direct costs. The direct cost margin is a Medicare margin that is calculated using only direct patient care costs and not overhead and capital. This margin was 34 percent in 2010 for hospital-based IRFs. In addition, acute hospital margins are 1.6 percentage points higher for acute hospitals with an IRF unit than for those without an IRF. These data indicate that IRF units are able to more than cover their direct costs and, therefore, financially contribute to their parent hospital.

As part of the Commission's analysis of rural payment adequacy, we conducted additional analyses of rural and urban IRFs, and I will discuss these over the next few slides.

As a reminder, rural IRFs receive a payment

adjustment which has been set at 18.4 percent since fiscal year 2010. We first looked to see if the relationship between volume and margins existed among both urban and rural IRFs, and we found that it did. As you can see on this slide, Medicare margins increase as volume increases for both rural and urban IRFs.

Next we looked at Medicare margins, costs, and payments per case. The data on this slide suggests that the rural adjustment is not having a uniform impact on all IRFs in rural areas. Rural IRFs that are adjacent to urban areas appear to be an anomaly. Their Medicare margins are negative 5.6 percent compared to 4.3 percent for micropolitan rural IRFs and over 16 percent for rural IRFs that are not adjacent to urban areas. In addition, rural adjacent IRFs have the highest cost per case, and their cost per case is higher than their payment per case.

We further researched differences between the rural adjacent to urban IRFs and other categories of IRFs. Rural adjacent IRFs have low volume, and as we have shown, there is a relationship between IRF volume and Medicare margins. Specifically, they have the lowest median Medicare and total discharges, the smallest median number of beds,

and the lowest occupancy rates. However, their case mix index is consistent with rural nonadjacent IRFs and urban IRFs, and their occupancy rates are not much lower than those of rural nonadjacent IRFs.

We will continue to look into the differences between types of rural IRFs, and we would appreciate any suggestions for additional research that you have.

As we have seen, aggregate Medicare margins for IRFs in 2010 were 8.8 percent. To project the aggregate Medicare margin for 2012, we modeled the policy changes indicated on the slide for 2011 and 2012. We estimate that Medicare margins for 2012 will be 8 percent.

In summary, our indicators of Medicare payment adequacy for IRFs are positive. Supply and capacity are stable and adequate to meet demand, and volume is relatively stable. Preliminary risk-adjusted quality-of-care estimates indicate that quality of care incrementally improved since 2004 and that there are still areas for quality improvements. Access to credit appears adequate for both hospital-based and free-standing IRFs. Finally, we project that 2012 aggregate Medicare margins will be approximately 8 percent, down from the 8.8-percent margins in 2010. To the

extent that IRFs restraint their cost growth, the projected 2012 margin could be higher than we have estimated.

The Chairman's draft recommendation for your review is: The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2013.

On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the payment in 2013. We estimate that this recommendation will decrease federal 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 Medicare beneficiaries is expected.

This concludes the presentation, and Craig and I welcome any questions.

MR. HACKBARTH: Thank you, Christine. Karen, I think we're starting with you this time. Clarifying questions?

DR. BORMAN: None.

DR. CASTELLANOS: The compliance threshold, I know that has been a big issue in this sector. Has that been -- let me be very blunt. In our community -- and I'm not saying it's appropriate or not appropriate -- we do a tremendous amount of knee and hip replacements. We have twice the population increase in the age group, and, you know, in any age group, we have a lot more co-morbidities. It is occasionally difficult because of the compliance issue to find appropriate post-hospital care for these patients.

Has that been an issue anywhere else that you have noticed?

MS. AGUIAR: Are you talking about in the sense of a physician or provider that's been trying to find a placement for those patients?

DR. CASTELLANOS: No, I'm talking about from the hospital discharge to an appropriate --

MS. AGUIAR: Right. So we do have -- wait a second. I'm trying to pull up the paper that's in our paper. We do look at acute hospital discharges to settings of care.

MR. HACKBARTH: So, Ron, what I hear you saying is that although, I think, increasingly patients with hip and

knee replacements are discharged home, you have a population that has co-morbidities and going home may not be the appropriate place for them. And so you're having difficulty finding places. Is that --

DR. CASTELLANOS: The hospital tells me, the discharge planners tell me that is a problem. I have personally not experienced that.

MS. AGUIAR: Just to follow up, because I found the table -- and, again, this is in the mailing materials. So the analysis that we do is we look at acute-care hospital discharges, and the ones that we highlight in the table are for major joint replacement patients, hips and knees, and then for stroke. And so what we found is we found a decline in the number of major joint replacement cases going to IRFs between 2004 and 2010 and an increase in the ones going to SNFs and to home health. So to give you a sense, in 2010 it was about 12 percent that were discharged to an IRF, 38 percent that went to a SNF, and 32 percent that went to a home health.

DR. CASTELLANOS: I guess that's not my question. My question is: Some of these patients perhaps are not appropriately placed in the best care facility. Has anybody

complained to you concerning that? That's the issue I'm --

MS. AGUIAR: Yeah, I think we have heard that issue from the industry, and I don't want to speak for them, but if I were to sort of summarize just my understanding of what their concern is, you know, they sort of do where that they would like to be able to care for these patients, but, again, because of the 60-percent rule, those patients are being sent to SNFs and to home health. You know, we always track quality-of-care measures in any setting, and so if we were to sort of see that there was an issue in terms of access or in terms of quality of care for those patients, we would definitely be responding to that.

Did you want to add anything?

MR. LISK: Yeah, in some cases the other issue that comes up that we've heard in the past -- I haven't heard as recently, but it may still be an issue. Sometimes it's the RACs and the MACs who end up reviewing the cases and end up denying the reimbursement for the cases that go there because they say they didn't need to go to an IRF, they could have gone somewhere else. And I don't know what issues were with the placement of those patients before, so that's kind of one of the issues that comes up that we've

heard from the industry.

DR. CASTELLANOS: [off microphone] Maybe we can talk separately.

MR. GEORGE MILLER: Thank you again for this report. It is always helpful for me -- and I think you did it one of the other reports -- to have a map showing where the IRFs are. That is always helpful for me.

Then I didn't read in the chapter -- at least I didn't see it; I don't know if I read it -- any demographic information on who the patients are and where they come from. Is it there and I just missed it.

MS. AGUIAR: It is. Afterwards I'll show you the exact page where it is.

MR. GEORGE MILLER: Afterwards, all right. Thank you.

DR. HALL: On page 3, just a point of clarification that might be useful. The criteria for getting into an IRF -- actually I never heard it said that way, "IRF," but I like it -- is very stringent, right at the top point there. The numbers of patients that can actually comply with the basic requirements of having to have two different types of therapy, but particular three hours a

day, that's a big deal. So this is a relatively small percentage of the population. I think we have to understand that this is not for everybody, and that often the choice of where people go is very much determined by whether they can meet those two criteria. In my experience, the people who run these centers are very, very strict about that because they're going to get dinged if they don't.

I think as a partial answer to your question, Ron, why it may be different in an area of the country where you have a higher concentration of older people, particularly old-old, they never make criteria for this. That may be one of the reasons you're having a problem getting them in there. They just absolutely won't -- they just can't do three hours a day. So this is a relatively small segment, an important segment but small.

Thank you.

MR. KUHN: Bill's absolutely right. The nature of the intensive rehabilitation in IRFs is remarkable when you think about what these folks do for Medicare patients and other folks that need that level of care.

Christine, a question I had had to do with the compliance threshold, and in particular, the issue that you

noted of joint replacements, the hips and knees in particular, where CMS put those certain restrictions on there. And when you look at the table, where you really start to see that decline was about in 2006, and it dropped dramatically down to 2008 and then has slowly been going down since. The rate of decline is in the 13- to 14-percent range, if I remember right from the table.

So I guess the question is now that we've had about four years of experience with people having joint replacements getting therapy and other sites of service, as you mentioned, skilled nursing facilities and home health, what's the quality that we're seeing now as a result of that change from some of the data we've been able to look at?

MS. AGUIAR: So I could only -- I can't completely answer your question, but I'll partially answer it. So we've added this year, you know, risk-adjusted quality measures in the IRF sector. We did it at the facility level to the aggregated up, and so we haven't looked at by specific conditions yet. And I think for us to be able to answer that question, we would have to work across with the colleagues that, you know, are in the SNFs and the home health to see if we could sort of, you know, be able to

develop risk-adjusted quality measures that would be applicable in every single setting. If I'm not mistaken, Mark, I don't think we have that yet.

DR. MARK MILLER: [off microphone] your question is what about these people who showed up in SNF and home health, and I think that's what you're saying. And I think what we'd have to do is see whether we could support disaggregating - identifying and then disaggregating down to that level with the measures we have, because we have broader measures in those settings, but specific to these patients, I'd have to just go back and see whether it's something we could do.

MR. KUHN: Okay. And the second question, and a little bit it goes back to the conversation we had on hospice and the conversation of everything coming together on the right side of service, and ultimately driving to a site-neutral payment system. As Glenn had mentioned earlier, a lot of that is going to be driven by the care tool that CMS is developing where we'd have a standardized assessment instrument across all post-acute care settings.

What's the current status with CMS on that care tool right now and the development?

DR. MARK MILLER: Okay, and I would take an assist here if anybody needs to. My understanding is that the work is largely completed and it's in clearance.

MS. KELLEY: [off microphone] Yes, that's right.

DR. MARK MILLER: Okay. I would just like it noted for the record I was correct on this point.

[Laughter.]

DR. MARK MILLER: And I'd specifically like it notes to Cori that I was correct on this point.

MS. UCCELLO: A broken clock is right twice a day.

[Laughter.]

MR. BUTLER: So on Slide 8, I want to try to get at a little bit the relationship better of the hospital-based versus the free-standing to these data. This begins to -- I'm thinking back to the SNF discussion of yesterday. This is the beginnings of kind of the readmission kind of rates, but it doesn't break it out for the hospital-based units versus the free-standing. You probably can do that, though.

MS. AGUIAR: I have to check before I promise that we can do that. I know that our contractors, they're preparing a contractor report, and they have done that. But

we would have to go back to see internally to discuss whether or not we can do that, if we can do that in time for January. So I'd have to get back to you on that.

MR. BUTLER: It might be another one of those sectors where you compare the rewards and penalties on both sides of the equation, the hospital and the IRFs.

The second somewhat related question is I know we've documented that hospitals with hospital-based SNFs are actually more profitable than ones without SNFs. So I'm wondering in the same vein here, do hospitals -- you know, so even though they've got a negative margin, is there, do we know --

MS. AGUIAR: Yeah, I did quote -- and I'm sorry if it didn't come out very clearly. I did quote a percentage. I think I said 1.6 percent percentage points that are margins if you do have a hospital-based unit. But Craig did that analysis, so he can speak more to it.

MR. LISK: Yeah, I mean, the overall margin for hospitals that have an IRF, overall Medicare margin is 1.6 percentage points higher.

MR. BUTLER: Okay.

MR. LISK: For Medicare. And, in fact, also

because the -- you know, that has a couple effects. We see the inpatient margin a little bit higher. We see the other margins higher. But the overall margin comes out a little bit higher.

MR. BUTLER: And so then clarify for me one more time on that -- obviously, you've documented the economy-of-scale issue as being the principal variable explaining perhaps the difference of performance in hospital-based versus free-standing, and then the hospital-based people say, yeah, well, you still haven't documented the patient mix difference, even though you've got broad category, there can be more -- where do you see that going, if anywhere, beyond what data is already available in terms of -- and I know you've documented that the category is in here, and it says roughly the same kinds of patients are treated in each. But is there a deeper dive or another way that's going to be supported by some of the other assessment tools that are coming down the line?

MS. AGUIAR: What we have on that so far, which is in your mailing materials and which we didn't present here, is we do a standardized cost analysis. So just looking at the cost size, we do adjust that for case mix, for wages,

and for outlier. And so there was a statistic that, again, is not on the table but that I did say that hospital-based is about -- I think it's about 34 percent higher adjusted cost per discharge than the free-standing. So, you know, there is that. I don't know if you were wanting more than that.

MR. BUTLER: I'm asking is the case mix classification sophisticated enough to pick up the severity of the patient illness. I understand you do cost mix -- you do adjust using the existing --

MS. AGUIAR: Right.

MR. BUTLER: -- you know, methodology of categorizing patients, so okay.

DR. DEAN: I would just reiterate what Bill said about the difficulty and the demands of the three hours a day. We've encountered exactly that same thing with a lot of elderly folks. They'd actually probably do better in a skilled nursing setting. They get many of the same services. It's less intensive. It's a little more gradual. So the services are there. It just isn't officially a rehab facility.

MS. BEHROOZI: So you just referred to the table

that describes the characteristics of low-cost and high-cost facilities. Have you or can you cross-walk that with the quality scores on our efficient provider quest kind of --

MS. AGUIAR: Right. So we had tried to get that done for this particular presentation. You know, it's a process. It was a good process, but just a lengthy process to get the risk adjustment measures done.

So we are working on that now, and I am hoping to have that for the January presentation.

MR. HACKBARTH: [off microphone] Okay. Round two.

DR. BORMAN: I generally support the recommendation.

MR. GRADISON: As I do. Thank you.

DR. CASTELLANOS: [off microphone] I support.

DR. STUART: I support the recommendation.

MR. GEORGE MILLER: Support.

MS. UCCELLO: I support the recommendation, and then, you know, I think I mentioned this yesterday, but going back and looking at these rural-urban adjustments and focusing on how well or not well targeted they are and assessing whether low volume is the right level to use rather than the urban-rural.

DR. HALL: I support

MR. KUHN: I support the recommendation.

DR. BERENSON: I support the recommendation. I just wanted to make one comment thinking about Bill's earlier remarks that Tom supported. It's interesting that here the screening criteria are quite effective, and we've just gotten through home health and hospice where the screening criteria failed miserably. It may be interesting to sort of think through why that is. I mean, I have some preliminary notions, but maybe we should do that.

DR. BAICKER: I support the recommendation.

DR. NAYLOR: I support the recommendations.

MR. BUTLER: I support the recommendations and add that I think the 60 percent has been about right, and it's mostly been about getting the hips and joints into skilled nursing and other settings that are a lot cheaper. That's not to say that the rehab units weren't doing really good jobs, maybe even more focused jobs, but, you know, the other settings -- so it seems like we kind of got this one in about the right balance right now.

MR. HACKBARTH: I do like Herb's idea. We have encouraged the significant shift in location for the hips

and knees, move them out of the IRFs, the highest-cost setting or higher-cost setting, into others. That's been going on for a while now, to look back and say, okay, what is the evidence of the impact of that on quality for patients I think is a good thing to do.

DR. DEAN: I support the recommendations.

MS. BEHROOZI: I support.

DR. CHERNEW: I support the recommendation also and think this is just another area where thinking of a bundling of a hip or a knee and across these settings with a quality measure for the type of care as opposed to where you got it is just a much better philosophical way to go.

MR. ARMSTRONG: You just couldn't resist that, could you?

DR. CHERNEW: I have the same thing. I just say it again.

MR. ARMSTRONG: I support this, too.

MR. HACKBARTH: I think Joe Newhouse and some colleagues wrote a piece on bundling and where you might want to start a bundling of hospital and post-acute care, and I think that hip and knee replacements was high on the list for a number of different reasons.

Okay. Thank you very much, Christine and Craig.

We're now onto our final session on long-term care hospital services.

MS. KELLEY: Good morning. I'm going to talk about LTCHs, as Glenn said. First, I'll run through just some background information, just to remind you where we are.

Patients with medically complex problems who need hospital level care for 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 Medicare length-of-stay of greater than 25 days.

Due to these long stays and the level of care provided, care in LTCHs is expensive, averaging more than $38,000 per casein 2010. Medicare pays LTCHs under a per-discharge PPS and the PPS uses the same MS-DRGs as the acute hospital PPS but with different weights specific to LTCHs. Payments can be adjusted upwards for cases with extraordinarily high costs, or downwards for short-stay outliers.

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 covered by the acute care PPS. As a result, CMS implemented regulations like the 25 percent rule, which limits the number of patients a hospital-within-hospital can admit from its host hospital.

Between 2005 and 2008, as you can see here, growth in spending slowed to less than one percent per year. Then, in MMSEA, Congress rolled back or delayed implementation of some of these regulations. Spending at that point for LTCH services began to climb again, rising 12 percent between 2008 and 2010 to reach $5.2 billion.

So I'll turn now to our update framework. Our first consideration is access to care. We have no direct indicators of beneficiaries' access to LTCH services, so we focus on changes in capacity and use. But it's important to keep in mind that this product is not well defined. There are no established criteria for admission to an LTCH so it's not clear whether the patients treated there require this level of care. Remember that many Medicare beneficiaries

live in areas without LTCHs and so they receive similar services in other facilities.

To gauge access to services, we first look at available capacity. This slide shows the number of LTCHs nationwide. From the late 1990s until 2005, the number of LTCH more than doubled. This growth leveled off between 2005 and 2008, that period when CMS implemented those payment regulations that limited the growth in spending.

As I showed you, spending began to climb again between 2008 and 2009, and you can see here that the number of LTCHs did, as well, rising 6.6 percent. This was surprising to some observers because of the moratorium that Congress imposed beginning in July, 2007 which prevented the opening of new LTCHs and of new LTCH beds. But exceptions to the moratorium were made for LTCHs that were already in the construction pipeline. So that exception allowed this influx of new facilities that you see here.

It appears now that the surge has passed and there was a net increase of just one LTCH between 2009 and 2010.

In controlling for the number of fee-for-service beneficiaries, we see that the number of cases has grown 3.5 percent between 2009 and 2010. So taken together, these

trends suggest to us that access to care has been maintained during the period.

Let's turn now to quality. As you know, LTCHs do not submit quality data to CMS so we rely on claims data to examine 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 2010, these rates were stable or declining for most of the top diagnoses.

Of course, we've long been concerned about the lack of quality data in LTCHs, and you'll recall that last year we convened an expert panel to elicit information on how to best measure quality in LTCHs. As required by law, CMS is implementing an LTCH pay-for-reporting program beginning in October 2013 with data collection beginning October 2012. To start, CMS has chosen three of the quality measures that were suggested by MedPAC's panel: catheter associated UTIs, bloodstream infections due to central lines, and new or worsened pressure ulcers. CMS plans to add other measures in future years.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access

capital it might, in part, reflect problems of the adequacy of Medicare payments since Medicare provides about 55 percent of LTCH revenues. The moratorium limits opportunities for expansion. But in 2010 the two largest LTCH chains, which together own slightly more than half of all LTCHs, acquired other LTCHs and other post-acute care providers. According to the chain's filings with the SEC, they have access to revolving credit facilities that they've tapped to finance these acquisitions.

These LTCH companies are increasingly diversified, both horizontally and vertically, which may improve their ability to control costs and better position the companies for any policy changes. Smaller chains and nonprofits may not have the same level of access to capital.

So how have LTCHs per case payments compared to per case costs? In the first years of the PPS, LTCHs appeared to be responsive to changes in payment. Payment per case increased rapidly after the PPS was implemented, climbing an average 17 percent per year between 2003 and 2005. Much of this growth was due to improvements in the documentation and coding of patients following the implementation of the new classification system. And during

this period, costs per case also increased rapidly, albeit at a somewhat slower pace.

Between 2005 and 2008, growth in costs per case outpaced that for payments, as those regulatory changes slowed the growth in payment per case to an average of 1.4 percent per year. After the Congress delayed the implementation of those regulations and CMS implemented a revised classification system, the MS-LTC-DRGs, growth in payments per case began to pick up again.

Between 2008 and 2009, per case payments climbed to 5.3 percent, about twice as much as costs. Between 2009 and 2010, per case payments rose another 2 percent while cost growth was held under 1 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 below zero under TEFRA to a peak of 12 percent of 2005. At that point, margins began to fall as growth in payments level off. However, in 2008, LTCH margins began to rise again.

So this slide shows 2010 Medicare margins for all LTCHs combined and for different LTCH groups as well as the share each represents of total providers and total cases.

As you can see in the top row, the aggregate Medicare margin for 2010 was 6.4 percent. There's wide spread in the margins, similar to what you've seen in other post-acute care settings, with a quarter of LTCHs having 2010 margins of minus 2.9 percent or less and another quarter having margins that are 14.6 percent or more.

Next we have margins for urban and rural LTCHs. Note that there are very few rural LTCHs overall, just 27, and that they provided only 5 percent of the LTCH stays in 2010. Such small numbers preclude us from further dividing rural LTCHs into smaller groups for the additional analyses that we've prevented for other sectors. However, we do know that rural LTCHs tend to be smaller, so their lower margins may reflect fewer economies of scale.

The last thing I want to call your attention to here is the ownership effect. As you can see, three-quarters of LTCHs are for-profit and they furnished 84 percent of the stays in 2010. Nonprofits tend to be smaller than for-profits, which again may in part explain their lower margins.

We looked more closely at high and low margin LTCHs to get a better idea of what's driving their margins.

Because LTCHs often operate in the red in their first year of operation, in this part of the analysis we included only LTCHs that filed cost reports in 2009 and 2010. Government LTCHs are excluded, as well. This slide compares LTCHs in the top quartile of margins with those in the bottom quartile.

As you see in the first two rows, lower standardized costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and highest Medicare margins. High margin LTCHs also tend to be marg er with mean total discharges of 576 compared with 444 for low margin LTCHs. High margin LTCHs have far fewer high cost outlier cases and lower high cost outlier payments. In addition, they have a lower share of short stay cases. Finally, high margin LTCHs are much more likely to be for profit.

For purposes of projecting 2012 margins, we modeled a number of policy changes. First, we included the updates in 2011 and 2012. For both years the update was adjusted by the PPACA-mandated reduction. In addition, in 2011 an adjustment for documentation and coding improvements was also made. This resulted in an update of minus half a

percent in 2011 and an increase of 1.8 percent in 2012.

We also made an adjustment for changes to outlier payments in both years which we estimated will increase aggregate payments. Altogether we estimate that these effects will result in somewhat greater growth in provider costs than in aggregate payments, assuming cost growth at the rate of market basket. So we've projected a margin of 4.8 percent in 2012.

So to sum up our update analysis, the number of facilities is stable in 2010, and we have seen some increase in the use of LTCH services. We have little information about quality in LTCHs, but mortality and readmission rates appear to be stable. The moratorium has limited opportunities for expansion, but may LTCHS do have access to capital for improvement to their current facilities. Our projected margin for 2012 is 4.8 percent. Our projected decrease in the aggregate margin is consistent with the expected effects of congressionally mandated reductions in payment updates.

There were some policy changes expected in fiscal year 2013 that will have an impact on both LTCH payments and likely provider behavior as well. As I mentioned, MMSEA

rolled back the phase-in of the 25-percent rule for hospitals within hospitals and prevented CMS from applying the 25-percent rule to free-standing facilities. Those provisions begin to expire in July 2012.

In addition, MMSEA prevented CMS from making additional reductions in payment for LTCH cases with the very shortest lengths of stay. That provision expires in December 2012. Finally, the moratorium on new LTCHs and LTCH beds expires also in December 2012.

We make our recommendation to the Secretary because there is no legislated update to the LTCH PPS. The Chairman's draft recommendation reads that the Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2013.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2013 will produce savings relative to the market basket, even assuming the PPACA-mandated reductions. We don't anticipate any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

Before I turn the discussion over to you, I wanted

to take a minute to talk to you about LTCH criteria. As you know, the Commission recommended that the Secretary develop patient and facility criteria to ensure that patients admitted to LTCHs are medically complex and have a good chance of improvement and that facilities have the capabilities of caring for these severely ill patients.

MedPAC has also noted that CMS should seek to define the level of care appropriately furnished in LTCHs as well as in the step-down units of many acute-care hospitals and some specialized SNFs and IRFs. Developing patient criteria with available data, however, has proven to be more difficult than anticipated.

MMSEA required CMS to report to Congress on LTCH criteria, and that report was issued last spring. Based on a review of the literature, the report suggested specific attributes of medically complex patients that might be used, for example, prolonged mechanical ventilation; multiple organ failure; multiple or chronic co-morbidities such as coronary artery disease, chronic obstructive pulmonary disease, stroke, or diabetes; or multiple community- or hospital-acquired infections or ulcers.

CMS' report also noted the difficulty in

predicting patient outcomes for medically complex patients. Research suggests that relatively few critically medically complex patients return to their previous level of health and function and that most end up with significant physical and cognitive limitations. It's important, therefore, that any potential patient criteria identify those medically complex patients who are likely to benefit from an LTCH program of care. Some of the most severely ill medically complex patients may not be appropriate for LTCH admission because they're too sick to benefit from specialized care or because their prognosis for improvement is so poor. Other options may be better suited to the patient's needs.

CMS also noted disparities across settings in Medicare's payment for medically complex cases, and this may be problematic because these disparities can influence providers' decisions about admission, transfer, and discharge. The Commission has long held that payment for the same set of services should be the same regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. CMS made no recommendations for LTCH criteria

but is continuing its work in this area.

So, with that, I'll go back to the recommendation and turn it over to you. Thank you.

MR. HACKBARTH: Thank you, Dana.

The message that I hear in that last part is that patient criteria is a way of making sure that this expensive resource is only used on the proper patients. That does not sound like a very fruitful path, at least in the short term.

MS. KELLEY: Yes, I think CMS has spent a significant amount of time and effort investigating this and I think repeatedly has come to what they consider to be dead ends in terms of definitively identifying the types of patients that are appropriate for LTCH care, especially when those patients are compared between areas of the country that have LTCHs and those that don't.

MR. HACKBARTH: So at the end of next year, the moratorium expires.

MS. KELLEY: Yes.

MR. HACKBARTH: And it might be reasonable to expect that the number of LTCHs will start to grow again.

MS. KELLEY: I think that's a reasonable expectation.

MR. HACKBARTH: Back when CMS first developed the restrictions on the 25-percent rule and the like, we were lukewarm towards those and preferred the patient criteria path as a sounder long-term approach. I don't think we ever came outright and opposed the 25-percent rule but said we thought of it more as a stop-gap as opposed to a long-term solution to the problem.

MS. KELLEY: That's right, and we also went on to say that as a stop-gap that is should be applied across all facilities and not just on hospitals within hospitals.

MR. HACKBARTH: And they did that.

MS. KELLEY: And they did do that, yes, and then that was also prevented by Congress in MMSEA.

MR. HACKBARTH: Yeah, but within a year, as I understand it, the moratorium expires, but then also the restrictions on the 25-percent rule and the short stay expire.

MS. KELLEY: The very short stay, that's right.

MR. HACKBARTH: Those will be the 25-percent rule applied across all LTCHs, and the short-stay payment rule will really be the only things in place to restrict inappropriate growth of LTCHs.

MS. KELLEY: Yes.

MR. HACKBARTH: Okay.

DR. MARK MILLER: And just to tease this out a little bit more, there's sort of this struggle within CMS, I think. Are we defining criteria for an LTCH patient or are we defining criteria for a person who needs a high level of care? And I think that's one thing to keep in mind, that maybe -- maybe -- you could talk about a high level of care, but that patient might be completely treatable in a step-down unit or some other setting. So that's a dilemma, and I think that's at least part of the reason CMS has said that this is a bit of a windmill to tilt at.

I think we are implicitly in your comments in this exchange coming to -- we had this idea awhile back. The environment has not moved forward and picked it up. And I think we're going to be faced again with perhaps some new ways to try and think about this.

A couple of things that occur to me are -- and these are just thoughts, not anything to put in front of you yet. You know, there is this volume -- this notion that Bill, not unlike IRF, there's a very small select set of patients that probably need this service, and should we be

thinking about, you know, what is the proper size and referral region for a provider like this. Another one is to say if you can't make a definitive criteria for an LTCH per se -- and maybe that in the end makes sense -- do you think about the payment systems that are now separate and bringing them more together and saying there may be some kind of -- okay, and I got a thumbs up from Mike, so I'll assume people can understand where that's going.

I think on the quality front we should continue to move down that, and we are definitely trying to get work out into the environment to try and inform that front. But we may have to come back to this and kind of revisit, not unlike we did several years ago.

I'm sorry about that break, but we've been internally trying to think about things.

MR. HACKBARTH: [off microphone] Okay. Clarifying questions?

MS. BEHROOZI: Yeah, I think it's related actually to what Mark was just talking about. In the paper you talk about how recent research showed that aggregate average Medicare margins for full episodes of care would be higher for patients who used LTCHs than for similar patients who

did not. Is that a function of the LTCH base rate? I'm wading into stuff that's way over my head, I guess, but why would the introduction of the LTCH in the episode of care raise the profitability component?

MS. KELLEY: The way that study was constructed put together the costs and the payments across different parts of an episode of care. So it's not a commentary on where exactly the profitability is higher but, rather, the profitability across the entire episode. So the researchers, to my recollection, did not identify sort of where the disparity existed but, rather, just pointed out that it did indicate some disparity in the payment for these patients across an episode of care.

DR. DEAN: What is the range of length of stay in these places? I think the mailing material says the average is 26 or 27 days or something like that, but I'm assuming -- and there was a concern about the short stays. What really was defined as a short stay? And do we see some really long stays or not?

MS. KELLEY: Sure. The range is very wide. The average is right at about 25-1/2 days, which is in keeping with the requirement for LTCH certification that they have a

Medicare length of stay of greater than 25 days.

We do see -- because of the way short-stay outliers are defined, basically always around 30 percent of cases will be defined as short stays. So, in essence, that's kind of a moving target, no matter sort of how -- if facilities get better at identifying patients, they're still going to get tagged as short-stay outliers because of the way the formula is constructed.

But we do see, like I said, about 30 percent of cases are short stay, which is based off the average length of stay for the LTCH for that MS-LTC-DRG, and then about half of those cases are what CMS would call "very short stay outliers," which are within, I believe, one standard deviation of the mean for the MS DRG in the acute-care hospital, not in the LTCH. So that's what they're defining as very similar to a short stay acute care hospital case.

DR. DEAN: So those would be five, six, seven days or --

MS. KELLEY: Yeah, you know, they --

DR. DEAN: And the long stay is what? What do you see at the other end?

MS. KELLEY: It can be very long, but I don't want

to misspeak, but it can go well beyond 25 days.

MR. BUTLER: So as we're concluding this march through the post-acute sector and seeing it all kind of flip more to the for-profit side, and as Glenn said, well, it's not just the for-profit, it's -- well, I won't get into it. This one is under control in the sense that you've got the 25-percent screening and you've got the moratorium. But is there anything else about this sector of the post-acute that you think would be maybe less subject to manipulation than others? Or is it very much like the others and we just kind of got our hands around it because of maybe crude but effective in the short run constraints?

MS. KELLEY: I think that the requirement for at least a 25-day length-of-stay average does to some extent limit admission to these facilities. I think it's fair to say that the majority of these patients are very sick. When I looked at severity levels for 2010, I found that close to 80 percent -- about 87 percent of patients fell into APR-DRG 3 and 4, so severe and extreme cases. Of course, those are designed for acute-care cases, but it does give us a sense that they are very sickly patients.

I think that one interesting place -- one

interesting thing that I found this year was looking more closely at the very short stay outliers, those ones that have lengths of stay that are within a standard deviation of the acute-care hospital mean. And what I found there was that those patients actually seemed to be more sick on average, to have more co-morbidities, they had a much higher rate of mortality in the facility and mortality within 30 days and within a year. And what that suggested to me was perhaps some difficulty identifying which patients can benefit from an LTCH length -- you know, that sort of long length of stay and the care that's provided there and which patients are simply too sick to benefit, because it seems to me that the LTCH would try to avoid admitting those patients that they think would die very quickly or be discharged very quickly.

MR. BUTLER: So am I right in assuming, let's say, the IRF, the 60-percent rule kind of largely was about hips and knees, and you could identify a specific population that was now being sent elsewhere. This you think is -- it's hard to identify exactly which patients are being affected, yet it is having some effect.

MS. KELLEY: That's how I would characterize it,

yes.

MR. HACKBARTH: To me it seems like this is a more problematic case than IRFs and more challenging to make sure that this expensive resource is applied to the -- I think it's a real challenge.

DR. NAYLOR: May I build on that? The high mortality rate within short time of admission and certainly within a year, how does -- or does the hospice benefit interact with this program, meaning, you know -- well, I don't know.

MS. KELLEY: The discharge rate to hospice is very low, so I would say they're not well integrated and it's not really sort of a path that is taken. The discharge rate is highest to SNFs, but some patients do go home with home health care and a small share go home without any sort of identified -- you know, they may have Part B therapies, but not with home health. As you noted, within a year, almost half of the patients are dead, so this is a severely debilitated, to use that word that was used earlier, and disabled population.

MR. HACKBARTH: Mary, I can't remember if we've discussed this since you've been on the Commission, but one

of the unique characteristics of LTCHs is that they are not uniformly available across the country. In fact, there are very large portions of the country where there are no LTCHs and the patients are cared for in other settings. So the -- Dana, go ahead.

MS. KELLEY: Well, it might be interesting to see whether there is a higher use of hospice in areas that don't have LTCHs.

MR. HACKBARTH: Yes.

MS. KELLEY: I have not looked at that. That might be interesting to look at.

MR. HACKBARTH: Yes.

DR. NAYLOR: I have to say that I found that diagram --

MR. HACKBARTH: Yes, that's right, the map and --

DR. NAYLOR: -- your diagram just so --

MR. HACKBARTH: Yes.

DR. CHERNEW: I don't think of these patients -- maybe I'm wrong -- as being the same as the hospice-type patients, although maybe I don't know what they're getting in here compared to some of the other settings. I might not --

DR. NAYLOR: I don't know, either, but I do know that the very high death rate -- 15 percent within 30 days and over 50 percent within a year -- suggests there might be a path for some of these that is not true LTCH.

MR. KUHN: A couple quick questions. One, Dana, on the quality measures and the pay for reporting that begins in FY 2014, will that information be publicly posted, then, to Hospital Compare?

MS. KELLEY: I don't know the answer to that.

MR. KUHN: Okay. And then -- let me save it until round two.

DR. HALL: Dana, you alluded to the fact that there have been some observations on patient outcomes in areas of the country that don't have access to LTCHs, if I heard you right. Could you elaborate on that at all?

MS. KELLEY: [Off microphone.] -- outcomes?

DR. HALL: That there have been studies that say, look, in our particular part of the country, there are no LTCHs --

MS. KELLEY: There have been --

DR. HALL: -- comparable patients --

MS. KELLEY: Sure. There have been a number of

studies that have attempted to look at patients who use LTCHs versus similar patients who don't and to try and look at --

DR. HALL: Right.

MS. KELLEY: -- outcomes and costs and the sort of trajectory of their care. Those studies are always hampered by a difficulty in identifying which patients do look like the LTCH cases, and there were some recent studies by RTI that looked at services -- LTCH patients or care for LTCH-type patients in three States with a high number of LTCHs versus some comparable States that don't have any or don't have many. And that did show some interesting differences, particularly in costs of care.

But I don't -- but, generally, the research has supported -- the initial research that the Commission did back in 2004, which showed that costs for patients who use LTCHs tend to be quite a bit higher than for comparable patients who don't except for the most severely ill, particularly the ventilator-dependent patients -- outcomes is something that is very difficult to look at because of the lack of assessment data in LTCHs, but also in acute-care hospitals. So it makes it difficult.

DR. HALL: Right.

MS. KELLEY: That is part of the difficulty in identifying the really similar patients here, really confined to comorbidities. And so other than sort of gross measures of mortality and readmission, there isn't much to look at.

I do think that -- well, I'll stop there.

DR. HALL: Yes. I think the whole point is that when you have a subsystem of care that has no criteria for entry, no quality data whatsoever, outcome studies are almost impossible, and it's going to take years to figure that out after 2014. This may turn out to be kind of an evolutionary dead end.

MS. KELLEY: Well, we are very hopeful that the research that CMS did on its care tool will provide us with some answers in terms of looking at patients across post-acute care settings.

MS. UCCELLO: Maybe you mentioned this or it's in the text, but where are these patients coming from?

MS. KELLEY: Three-quarters of them come directly from the acute-care hospital and about slightly less than a quarter come directly from the community.

MS. UCCELLO: And in the text, you said that there's been large growth in the cases admitted with infections.

MS. KELLEY: Yes.

MS. UCCELLO: And I'm wondering if that just reflects a general increase in infection rates or are acute-care hospitals shifting those people.

MS. KELLEY: It's not entirely clear to us. I think -- is Craig here? I think we also see that rise in the level of infections in the acute-care hospital, as well. So it's not clear whether this is sort of a general phenomenon or whether -- it does seem like it's more of a general phenomenon, but we're not really sure where it's coming from.

MR. GEORGE MILLER: First, let me thank you for the map, because it's very helpful to look at that map to see where these are located.

I was struck with the demographic information, and I don't know what to make of it, but the African Americans are more likely to be in LTCH. You cite some reasons. Have there been any further studies? And then what about other minorities? Do they participate equally or less, or is

there a trend?

MS. KELLEY: I haven't seen any more recent work, but I will go back and look again to make sure I've captured anything that might have been done more recently. I think -- no, my recollection is that other minority groups are not over-represented in this population, although, as you pointed out, African Americans are.

MR. GEORGE MILLER: Yes, and then that leads me to the Commission has talked about quality measures, and particularly the mortality rates are a little bit of a concern.

Second question, then, remind me, what are the copay and out-of-pocket expenses for an LTCH, particularly those who are referred by a hospital? Do they meet it --

MS. KELLEY: It's under Part A --

MR. GEORGE MILLER: Part A --

MS. KELLEY: -- so if they've met it in the hospital --

MR. GEORGE MILLER: -- in the hospital, they're okay.

MS. KELLEY: Yes.

MR. GEORGE MILLER: So there's not more of an out-

of-pocket expense. Okay. Very good. Thank you.

[Pause.]

DR. BORMAN: A couple of clarifying questions, Dana. You've done a really nice job of trying to sort through, and it's a little bit difficult. If you go back one slide to the -- or maybe two slides, sorry -- to the one where the CMS criteria attempt -- given these, do we have anything from this that would tell us what percentage of patients fell into the prolonged mechanical ventilation, because my personal experience would suggest that's the overwhelming percentage here. Do we have anything that's even a ballpark guess about that?

MS. KELLEY: Sure. You mean in the LTCH?

DR. BORMAN: Yes, in the LTCHs.

MS. KELLEY: In the LTCH, about 13 percent of patients are in the prolonged mechanical ventilation, MS-LTC DRG, and that is by far the largest.

DR. BORMAN: But only 13 percent?

MS. KELLEY: Yes.

DR. BORMAN: Okay.

MS. KELLEY: However, it is still a pretty concentrated population. The top 25 DRGs account for more

than half of the patient population.

DR. BORMAN: Is it conceivable they could be in under other DRGs where respiratory failure is a comorbidity and that's just sort of getting picked up that way?

MS. KELLEY: Uhh -

DR. BORMAN: Or we kind of don't know?

MS. KELLEY: About -- I think, overall, about 30 -- about a third of the patients are in some respiratory -

DR. BORMAN: Category?

MS. KELLEY: Yes.

DR. BORMAN: Okay. All right. And then the other question I would have is all of the numbers you have shown us, rightfully, for the purposes of this Commission, have been for the Medicare users of this. Do you have any sense of sort of what part of the book of business is Medicare in this, just because from my personal experience, while perhaps not on a dollar way because they may, in fact, be underfunded, but that in a numerical way, that there's almost like a dichotomous population here of somewhat younger people that have had some devastating illnesses.

MS. KELLEY: Yes. I think that's my understanding, as well. The Medicare, on average, accounts

for about 55 percent of revenues in these facilities, and slightly more of the patients. But certainly in the LTCHs that I've been to, there is that dichotomous population, yes.

DR. BORMAN: Those are my round one questions.

MR. HACKBARTH: Okay. I'll come back to you for round two in just a second, Karen.

Could you put up Slide 9, Dana. Every year, we look at an updated version of this, and it strikes me every year as a really peculiar pattern. Now, if this were a largely not-for-profit industry, this wouldn't surprise me so much. Payments go up. Costs go up sort of with them, lagging somewhat behind because not-for-profit institutions, when they have margin, they tend to reinvest it in their mission, spend the money, and so costs rise along with payments. We see that in our acute hospital analysis.

But we also see in the acute analysis a different pattern for for-profits. Their costs do not necessarily rise in tandem with the payments. They put more on the bottom line in that situation.

Here, we have a largely for-profit industry exhibiting a behavior that I come to associate with not-for-

profits --

MS. KELLEY: And a growing and increasingly for-profit population, as well.

MR. HACKBARTH: Right. And, you know, it just -- I wonder if there is some information in that, any theories as to why this is, because it's so -- the break is so sharp. You know, as soon as we move to prospective payment, both the payments and the costs go up. What caused that sharp -

MS. KELLEY: I think in the early years of the PPS, for sure -- well, no, I --

DR. MARK MILLER: [Off microphone.] There was a lot of growth a that --

MS. KELLEY: Yes.

DR. MARK MILLER: There was a lot of growth at that point, too.

MR. HACKBARTH: But this is all --

MS. KELLEY: But this is on a per case basis.

DR. MARK MILLER: Agreed.

DR. BAICKER: You can tell, too -- I'm making up theory here based completely free of data, which is liberating.

[Laughter.]

DR. BAICKER: You could tell causality going two ways. You could imagine that if our payments were well structured to underlying rises in cost and that we raise payments because costs were going up, they would track. The sharp break seems a little suspicious there, so you could tell causality the other way, where when payments get more generous, it becomes more profitable to be in the business and to reach further into the distribution of higher-cost cases that used to not be profitable but become profitable as payments rise per case.

MR. HACKBARTH: [Off microphone.] -- so the fact that --

DR. BAICKER: But they see more than we do in terms of risk adjustors.

MR. HACKBARTH: Yes.

MS. KELLEY: This is not case-mix adjusted.

MR. HACKBARTH: [Off microphone.] Oh, it is not?

MS. KELLEY: No.

MR. HACKBARTH: [Off microphone.] -- more into the complicated cases as a result of the new payment system. Okay.

DR. MARK MILLER: And what I was remembering is

when this really took off, there was a lot of interest in the investment community in this area, and what I was trying to get to was that you could imagine a period of time where they're sort of entering and they're not as profitable but expecting to be more so over time, and so -- and then people sort of entered and started putting restrictions on it --

MS. KELLEY: Yes, that's what I was going to say a minute ago, is that the entry into the market about that time was pretty striking, so that theory, I think, does make sense.

MR. HACKBARTH: Okay. So we're going to begin round two. We're going to let Karen go first. Karen.

DR. BORMAN: I just wanted to offer some commentary from some boots-on-the-ground experience as interacting with these institutions, having spent a lot of years as an ICU medical director and looking at the dynamics of what happens to critically ill patients, and having practiced both within and outside of parts of the country that have a greater concentration of these, as we've shown on our maps previously.

Certainly, at least in the non-Medicare populations, particularly in the younger aspect of the

population, these become homes where young people -- relatively young people -- who have had devastating injuries, occasionally some other diseases, but that really have had devastating injuries, primarily ventilator-bound, but occasionally just in a transition off a ventilator but with a long distance to go by virtue of having had multiple injuries that are going to take a long time to recover and the respiratory care drives it. In fact, a fair number of those patients are actually underfunded. It is conceivable that in the background going on here is some cross-subsidization from these rather large margins that we see on the Medicare side that enable care of these people who otherwise oftentimes have no other place to go.

In terms of the more typical Medicare-age population, I think this is much more often as a primary disease, somebody either with heart or pulmonary disease who has an acute exacerbation, winds up primarily with a respiratory issue that most acute-care hospitals are relatively pressured to move people along, out of the intensive care unit setting, may or may not have a step-down unit, and, in fact, that stay limit may also come into play, particularly on the financial side, and that these become

sort of a court of last resort, if you will, with the other fairly fundamental unmeasurable piece, which is the interaction of the family and the patient relative to end-of-life wishes. And it's no surprise that these people are not discharged to hospice because they're unable to live outside of a very supportive intensive care setting.

And so over time, in fact, many patients and/or families, and more often it's the families as surrogate decision makers, come to the realization that the patient is not improving, that this is the lifestyle that their loved one will lead or perhaps marginally better, and that they reach some sort of decision that previously they were unable to make in an acute-care setting or had not, there weren't advance directives and that kind of thing.

So that from an ICU leadership standpoint, you're very happy to have this option for care because it meets the needs of a group of patients who are quite ill but yet stably chronically ill for some period of time, and it's a testament to the medical science that we can keep almost anyone alive for some period of time with really good care, good technology, you know, and so forth, and it then becomes about the propriety of care and the wishes of the patient.

And that piece is just -- that factor is so huge in determining who goes to these places as opposed to who ends in another spot, because if you show the final outcomes, particularly for the Medicare population in this group, are dismal in terms of return to good function and quality of life and so forth.

So I think, number one, it's important to understand there probably is some cross-subsidy here. Number two, maybe to say that some of our efforts with regard to hospice, in regard to just a general public awareness of thinking about end of life, that whole discussion of an advance directive with your medical home or primary caregiver or "welcome to Medicare" visit or whenever it may be is a very important thing and we should continue to support those.

And then another piece in my mind that gets opened up is as we think more broadly and systemically about post-acute care, we've identified kind of some funny niche populations, as someone said earlier, that are in SNFs in terms of medically complex or perhaps in IRFs, and as we think about could there be an overlap of the functionality of this particular part of the program, they clearly would

have the ability to cope with a medically complex patient by virtue of the fact they're essentially providing intensive care, and should we be thinking more about some sort of program with options or a combined entity whose criterion is dealing with the medically complex and not so much measured by therapy needs and some of the other ways we apportion them into SNF and IRF and whatever going forward, obviously not something we can do in this update process.

But there is some capability here that could apply to those outlier patients in those other groups and vice-versa. It might make this entity a contributor to returning some individuals toward a more functional status and utilizing their capabilities. Just a thought.

But the reality is that this is primarily a dichotomous population. It's the older folks who have an exacerbation of preexisting disease, or it's somebody like me in 30 years that falls and breaks her hip and then can't get off the ventilator in three weeks in the hospital, and so it's a respiratory thing on top of an acute event, or it's a group of relatively younger people who've had a devastating illness or injury. The trauma population comes to mind as a big one here, particularly with brain injuries

that then lead to respiratory dependence, and they have different outcomes. And then in between is sandwiched this variable of the patient and family's thoughts about quality of life and decisions based on that.

MR. HACKBARTH: So, Karen, let me call on your experience. You said you practiced in the areas that have LTCHs and don't. Think in terms of the Medicare population, in particular, where there are no LTCHs available. What happens to that really complicated Medicare patient? Are they going to a SNF or are they staying in the acute hospital? Could you just reflect on that for a second.

DR. BORMAN: I think a certain fraction of them stay in the acute hospital. Almost all of them stay in the acute hospital a little bit longer. Then a certain amount will triage themselves as suitable, at least for the moment, of making it to a SNF, okay, and finding a SNF that will accept that medically complex patient, okay.

MR. HACKBARTH: Yes.

DR. BORMAN: So a certain fraction will do that. Then a number of them end up staying in the ICU. If the hospital has some sort of intermediate or step-down unit, they will go there. And a substantial number of the ones

who stay in the hospital will end up dying in the hospital as their illness progresses and/or the family works through the issues.

MR. HACKBARTH: So in communities that don't have LTCHs and at least some of the patients are ending up in the SNF, the SNFs presumably have different capabilities than SNFs have where there are LTCHs readily available as an alternative. Have we ever looked at how SNF margins compare in communities without LTCHs and with LTCHs, if, in fact, SNFs don't have to offer as many services, presumably high-cost services, when there's an LTCH available? If you're a SNF operating where there aren't LTCHs, it may be a particular challenge. Just a --

MS. KELLEY: I think Carol has been working on that, and Craig, are you involved in that, as well? No? I think Carol is working on looking at that.

MR. LISK: The only issue we know is that from our previous work is that medically complex patients, the SNFs don't do as well on, and that would be this population, if they're going to take them. You know, so that's the issue there.

MR. HACKBARTH: Okay. Karen, are you comfortable

with the recommendation?

DR. BORMAN: Yes. I'm comfortable with the recommendation as it stands.

MR. HACKBARTH: Okay.

DR. BORMAN: Thank you.

MR. HACKBARTH: Thank you.

MR. GRADISON: I support the recommendation.

DR. CASTELLANOS: Let me just take a strike at what question you asked Karen. We don't have a long-term care hospital service, but we have this type of patient. Most of them, as Karen said, either stay in the ICU or some form of SNF, which is usually hospital-based because they're the only ones who will take this complex patient. A few times, we've put them in an ambulance and let them drive 200 miles to a long-term care facility.

You know, what I'm trying to say very nicely is I'm looking forward to this care tool that CMS provides because this is a group of patients, this whole post-acute care, episodes of care, we really need to deal with more effectively and have a better direction or an overall path.

DR. STUART: I support the recommendation.

MR. GEORGE MILLER: I support the recommendation,

and just to piggyback on what Ron just said, and Karen, and it may be way out of our purview, but I'm struck with this map and locations and then looking at IRF and other post-acute care. I don't know if there are levers that we could maybe try to incentivize -- that may not be the right word because of free market systems -- but as we look at this population that needs to be treated, should there be more even distribution of those patients and where they can get treatment. And again, I look at most of the Midwest. Little or no places for them to go. And Ron's comment about someone having to drive 200 miles just seems to be interesting. I don't know if I have a solution. I'm not sure if there's a lever for us to deal with that issue. But I do think that we should move toward an opportunity to create post-acute care at the best possible setting and then pay for that setting, something that Mike would certainly agree with.

I support the recommendation.

MS. UCCELLO: I think George's last statement was exactly right. We need to figure out where the right place to treat these people are and I don't think we know yet. I'm not sure we want to see a very evenly distributed map

right now because we're not entirely clear of what's going on.

And in terms of kind of Ron's issue of having to send somebody far away, you know, you have to wonder, well, if we had a better SNF payment system that could pay people, or pay more accurately for complex cases, then that could help address that particular issue.

And Karen, thank you so much for providing that information. I think your perspective is really quite helpful to me as I'm thinking through this, because it's really just very difficult to know how to even think about this stuff. So your input is very helpful.

At the end, I do support the recommendation.

DR. HALL: I'm in support. As I mentioned earlier, I think we won't be able to figure this one out until we actually have some metrics that we can start to look at, so we'll come back to this, I'm sure.

MR. KUHN: I, too, support the recommendation, but let me also add my thoughts on why I think we need to come back and look at this issue more deeply in the future, and I think for many of the things that have been raised here, but a little bit of a different context on it.

One, I was at CMS when we implemented the 25 percent rule and the short-stay rule. I have a lot of history in this area, a lot of time before Congress explaining it to a lot of different folks. And Mary, just one thing for you, that was one of the reasons that drove the short-stay policy, is that we recognized very early on about the number of short stays that were -- that died at these facilities, and that concerned us very much.

But I think the reason for us to kind of begin to look at this is three things. One, as Glenn pointed out and Dana shared, the moratorium will be expiring at the end of next year. This has been a very long moratorium for purposes, and so this has been a sector of the health care industry that's been at rest under a moratorium for a very long time. So when this comes up, a lot of people are going to be asking a lot of policy questions about what's going on. So for that reason alone, I think this is worth looking at.

The second issue, I think, reason worth looking at is kind of what we've talked about here, is the need for some patient classification. MedPAC was early in on that, on looking at -- asking that CMS look at that. I think as

Dana reported, the report that CMS came out from its contractor was unable to come forward with a classification. And it's really unfair to this industry to kind of be in this kind of no man's land that they're in right now, because if you think about it, if you're an IRF, you have the PIE, the patient assessment instrument. If you're in home health, you have the OASIS instrument. And if you're a SNF, you have MDS, or the Minimum Data Set instrument out there. All you have is if you're an LTCH is an average length of stay of 25 days or more, long-term care, or an acute-care hospital with an average length of stay of 25 days or more.

I think they deserve better, and if there's a chance we can go back and look at that again, obviously, CMS has looked at it, we've looked at it, but the industry continues to say that they believe there are opportunities for classification and I think that's worth going back to look at it again.

And I think as Glenn noted, you know, is it defining an LTCH or is it defining the high level of care, and I think that might serve as a nice transition conversation into kind of the care tool discussion as we

continue to go forward.

The final and third reason I think this is worth looking at, and Glenn started to touch on this a little bit, is kind of the cohabitation of LTCHs where there are SNFs and kind of some of the activities. Some of the chatter in the industry right now is looking at what's going to begin happening in 2012. And as we all know, and we saw part of the conversation yesterday when we looked at SNFs, was that as a result of recent actions by CMS, there's going to be a drop of 11 percent for some case mix adjustments. We saw from the charts that their numbers went way up, to 24.5 percent. Now it's going to come down to 14 percent. But that 11 percent drop has got a lot of folks in the LTCH industry saying, are SNFs now going to take my medically complex patients? Was that enough of a drop to change the care patterns in some of these communities that are currently set up out there, as well?

So I think the interrelationship of these two organizations and the interrelationship of what CMS, the actions CMS took, I think, could change care patterns dramatically.

So I think for those three reasons, the fact of

the moratorium, the fact that we need to continue to, I think, strive for some criteria, and the change in SNF payment, are enough for us to kind of go back and look at this again.

DR. BERENSON: I support the recommendations.

DR. BAICKER: I support the recommendation, and it just highlights -- this discussion highlights some of the recurring themes of treating patients in the setting that is right for them, which implies some patient-centered metrics that are at least compatible across venues, if not the same across venues. And then also paying the same thing for the same service for the same patient, and the fact that we see such an uneven representation of LTCHs across the country suggests that we're not necessarily achieving those goals. So it seems like a great area to investigate further.

DR. NAYLOR: I support the recommendation. I want to highlight that home is a place that some people go with home health for the kind of services in addition to the places that Karen mentioned.

I think that this notion of looking at what is now a natural experiment with all of those States that don't have spots on them, to think about what we are learning in

terms of quality and use of resources, that should help guide the conversation and get us well positioned before the end of the year and the moratorium is up is really important.

And finally, I think that looking at it not just as post-acute but rather an episode, because the acute part of this is critically important, and some of these environments are holding on to individuals for longer periods of time because of lack of access. So I think looking at it as an episode of care is a good framework.

MR. BUTLER: I support the recommendation. I have been at my current organization, Rush, twice in my career, once in the 1980s and now now. In the 1980s, shortly after DRGs were implemented, is when I arrived. Our Chairman of Medicine was a pulmonologist and we knew right away we were losing a lot of money on intensive care patients that were on ventilators and, in fact, published articles on it. It led him to, with me and others, to establish an off-site LTCH, if you will, with another nonprofit organization for ventilator care, primarily, because it was clogging, as Karen would say, the ICUs with very long-stay patients that could be treated better, more effectively in another

setting.

That organization, it still exists to this day. We are no longer one of the owners, but two major health systems in Chicago are. We do provide the medical direction through our section head in pulmonary medicine. So it's kind of exactly what the right use of this is. It's probably got a vast majority are ventilator patients, and in an accountable care world, it's just the kind of continuity that you would want. So just more background information where it does work, at least for a certain segment of the population, better care at a lower cost.

DR. DEAN: I support the recommendation.

MS. BEHROOZI: I also support the recommendation.

DR. CHERNEW: I also support the recommendation.

MR. ARMSTRONG: Me, too.

MR. HACKBARTH: Yes. Each year when we talk about LTCHs, I think of Bill Scanlon. Bill always had a particular interest in the post-acute services and had done a lot of work in both Medicare and Medicaid over the years. And the point that Bill often made, which always comes back to me, is we talk about finding the right setting for the patients, which, of course, is the goal. But Bill said the

trick in post-acute is that the capabilities of the different types of providers are so variable, often based on what's in the community. So an example he would often cite is SNFs in a community without LTCHs would have a different set of capabilities than SNFs in communities where LTCHs are available.

So we don't have a homogeneous product that we're talking about in terms of facility capabilities here and we're trying to make across-the-board payment policy assessment. It's really difficult.

For me, where this ultimately leads is our oh so frequent destination, is what we want is somebody -- not payment by silos for these things, but we want somebody who is on the ground in a given community, knows the alternatives and what their capabilities are, and will properly match the patient to the right facility in that community, not abstract definitions, what they know about the particular providers in that community, and some sort of a bundled approach where there's an overall case manager for the transition from acute to post-acute care is really important, I think.

Thank you, Dana. As always, great job.

So we'll now have our public comment period.

[Pause.]

MR. HACKBARTH: And seeing nobody at the microphone, we are adjourned.

[Whereupon, at 11:28 a.m., the proceedings were adjourned.]