MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
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9:50 a.m.

COMMISSIONERS PRESENT:

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WILLIAM J. SCANLON, Ph.D.
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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests in the audience. Today, as you can see from our agenda, it is a devoted entirely to our update recommendations. We will take our final votes for the recommendations to be included in the March report. We are going to begin that with hospitals.

DR. STENSLAND: Good morning. Today we're going to discuss the adequacy of Medicare payments to hospitals. You will then vote on changing the level of those payments and vote on changing the distribution of payments among hospitals. You will receive some detailed information on the adequacy of payments in your mailing materials. In addition, we all discussed the payment adequacy indicators in some detail at last month's meeting. Rather than repeat it all, we will just present a summary of the findings from last month's meeting and then we'll open it up for discussion.

As we stated last month, you will discuss whether payments are adequate, taking into consideration the indicators of payment adequacy on this slide. In addition, the MMA requires that MedPAC consider the cost of the

efficient providers when making update recommendations.

Now, these same indicators you see here will be used to help evaluate the payment adequacy of all the sectors that we discuss as the day goes on.

The first topic for our session right here will be the update recommendation for hospitals, and second, we will discuss a recommendation to shift a portion of indirect medical education payments into a pay for performance program.

Most payment adequacy indicators are positive. Access to care remains strong with more hospitals opening them closing, hospitals are expanding their service offerings, and the volume of outpatient services per Medicare beneficiary continue to rise through 2007. We also see quality of care indicators such as mortality and process measures consistently improving.

Access to capital, however, has been volatile in 2008. After a record-breaking $30 billion in hospital construction in 2007 and strong municipal bond offerings last spring, the credit markets rose up in the fall. In the last two months of the year the bond offerings picked up somewhat but lenders are demanding higher interest rates on

fixed rate debt. Because the volatility and access to capital this year has been driven by factors other than Medicare payments, recent changes in access to capital may not be a good indicator of changes in Medicare payment adequacy.

The overall Medicare margin declined from a minus 4.7 percent in 2006 to minus 5.9 percent in 2007. Looking at the distribution of margins across types of providers, rural and urban PPS hospitals continue to have similar margins, while major teaching hospitals continue to have above average Medicare margins.

Today you will vote on how much payment rate should raise in 2010. Therefore, we may want to look forward to projecting what current margins would be if hospitals were paid under 2010 payment policies. We project that margins for the current year would fall to minus 6.9 percent if hospitals were paid under 2010 payment policies. This decrease in margins largely reflects the long-term trend of Medicare cost growth exceeding payment updates and exceeding the market basket of input prices.

However, it's important to note that the costs vary widely among hospitals, and the level of cost at

hospitals is not something that's randomly distributed. We find financial pressure to constrain costs is followed by lower costs.

We defined hospitals as being under financial pressure if they had median margins of less than 1 percent in stagnant or declining levels of net worth over five years. We found that in the years after they feel pressure these hospitals tend to keep their costs down to an average of 10 percent below the cost of hospitals that are not under financial pressure. The lower costs of those hospitals under pressure contribute to their higher Medicare margins.

Now, how could financial pressure affect costs? Here is a simple diagram to just illustrate how a hospital's level of spending per level of service can be affected by its level of resources.

Now, the next question is, well, why do we find financial pressure leads to lower costs? We may wonder whether there is a set of hospitals that can achieve these low cost and maintain high levels of quality.

To answer that question, we went and tried it to identify hospitals with strong quality metrics and low cost per unit of service. For a hospital to meet our criteria

for appearing to be a relatively efficient provider, it had to excel in at least one measure, meaning either risk-adjusted mortality or risk-adjusted costs are in the best one-third of all hospitals every year: 2004, 2005, and 2006. This is relatively strict criteria because we're requiring that the hospital be top-performing in all three years.

In addition, the hospital could not perform poorly on any measure. This means that risk-adjusted mortality, readmissions, and costs must all be either in the top third or the middle third in every year.

The one limitation of our approach is that it looks at per unit cost of production and not at overall efficiency in maintaining a person's health. Arnie has mentioned the importance of looking toward longitudinal efficiency where we track patient outcomes and total cost during the whole year.

The group up at Dartmouth has done some promising work in this area, and if we use Dartmouth data to identify hospitals whose patient base has a low annual cost of care, we could still find a significant set of hospitals that appear to do well on quality and longitudinal cost measures while breaking even on Medicare. We have not formally added

in the longitudinal measure of efficiency to the analysis because we are waiting for further refinements to risk adjustment and standardization of cost in those measures.

So let's take a look at these hospitals that we identify as relatively efficient. As we see here, the relatively efficient hospitals are able to achieve 14 percent lower mortality while having costs that are 11 percent below the median hospital. These lower costs are what allow these hospitals to roughly break even on Medicare.

In the past, you will recall that the Commission has discussed the variation in quality across hospitals and the commission has recommended a pay for performance program that would reward high-quality care. This year, given the indicators of payment adequacy and the desire to reward high-quality care, the Chairman's recommendation remains the same as last month. It reads: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2010 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive program.

The net effect of this recommendation is that

hospitals that provide high-quality care would receive more than a market basket index, of course, that while those that provide poor-quality care and do poorly on the quality metrics would receive an update that is less than the full market basket index.

Craig will now talk about the indirect medical education payments.

MR. LISK: As we've mentioned before, the IME adjustment is a percentage add-on to the PPS rates that varies with the number of residents a hospital trains.

In 2007, IME payments to hospitals totaled $6 billion and went to 30 percent of hospitals. The current IME adjustment, however, is set more than twice the documented impact of teaching on hospitals' costs.

Analysis we conducted for our 2007 March report showed that inpatient costs in teaching hospitals increased 2.2 percent for each 10 percent increment in teaching intensity, but the adjustment is set so that payments increased by 5.5 percent, resulting in a $3 billion subsidy to teaching hospitals with no direction or accountability for how these funds are to be used.

The size up the subsidy can be substantial. The

average major teaching hospital, for example, receives almost 23 percent more per case than a non-teaching hospital for the same case in a market. Having the adjustments set considerably above the true cost relationship contributes substantially to the large disparities in financial performance under Medicare. In 2007, the overall Medicare margin for major teaching hospitals was 10 percentage points higher than for non-teaching hospitals. The difference is even bigger, 16 percentage points, for the inpatient margin where the IME adjustment is made.

We have discussed and recommended in the past that we used the funds from reducing the IME adjustment to support a P4P program for hospitals. A one-percentage point reduction in the IME adjustment would provide roughly $1 billion to support P4P, providing a more focused and accountable use of these funds. It also would reduce the gap in Medicare margins between major teaching and non-teaching hospitals by up to two percentage points if P4P rewards were distributed equally across hospital groups. The reduction for major teaching hospitals would be less, though, if, on average, major teaching hospitals performed better on the P4P programs than other hospitals.

A one percentage point reduction would also move IME payments closer to the added cost of training residents but would still leave the adjustment set roughly double the empirical level. So, if we consider the typical major teaching hospital that I just discussed, their per case payments would still be substantial at almost 19 percent and they would continue to receive an IME adjustment that is sent a fall 10 percentage points above the empirical cost relationship.

For the last two years, the Commission has recommended that the IME adjustment be reduced by one percentage point to 4.5 percent. At the Commission meeting, several alternative options were discussed, but after some additional discussion, the Chair is proposing that we repeat last year's recommendation, which reads: The Congress should reduce the indirect medical education adjustment in 2010 by one percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the IME adjustment should be used to fund a quality incentive payment program.

We make this recommendation for a few reasons. We find that the IME adjustment is set substantially above the

effect teaching has on hospital costs contributing to large disparity differences in financial performance under Medicare between teaching and non-teaching hospitals. So, reducing this adjustment would help reduce this disparity.

Using these funds help support a pay for performance program also provides a more focused use of these funds that will benefit both teaching and non-teaching hospitals.

In terms of spending implications, this policy is intended to be budget-neutral, so it would have no effect on total spending. For beneficiaries and providers, there's potential for improved quality of care for beneficiaries because of the P4P aspect of the program. It would also narrow the disparity in Medicare margins across provider groups while making funds available to reward high-performing hospitals.

With that, we'd be happy to answer any questions and look forward to your discussions.

MR. HACKBARTH: Before I open it to our first round, which is clarifying questions, let me just underline a couple of things that Jeff and Craig said.

First of all, for the audience, I'd like to

emphasize that the recommendations are my recommendations, the Chairman's recommendations. They are not staff recommendations.

Second, I'd like to underline the effect of the hospital update recommendation. It's for full market basket, concurrent with implementation of a pay for performance program. We've recommended in the past that pay for performance be funded by reducing base rates by 1 to 2 percent and then redistribute that pool of money based on performance. What I want to highlight and emphasize is that means the guaranteed rate increase, if you will, for hospitals under this recommendation would not be full market basket but full market basket minus the amount that goes into the pay for performance pool. So to get to full market basket or more, a hospital would have to perform well on the quality measures. Mostly, that's for the benefit of the public audience and the reporters there.

So, with those initial comments, let's turn to round one, clarifying questions.

DR. BORMAN: I wonder if you could help me understand some material that was in the draft chapter that you didn't specifically show the table on this, and it's

when you -- the table that relates it to the high-, medium- and low-pressure organizations. There's a section that's labeled hospital characteristics. In the conversation or in the presentation and the materials, we talk a lot about the disparity in Medicare margins between major teaching hospitals and other groups of hospitals, but in this table the share of major teaching hospitals that were in the high-pressure group was over 50 percent, compared to less than 30 percent for the other levels of things.

So, I'm having a little disconnect here trying to reconcile, we are making argument based on this very large margin disparity, and yet over here we say this is a high-pressure group. So, can you help me reconcile that or tell me the fuzzy part of my thinking?

DR. STENSLAND: About half of the major teaching hospitals are in that high-pressure group, which indicates that if they want to grow their net worth, they are really somewhat dependent on Medicare profits, given the current cost structure.

But then there is another group of teaching hospitals that are in the low-pressure group or the medium-pressure group, and that's about another half of them.

In terms of what had happens with the teaching hospitals, we see the same pattern of cost differential where, amongst teaching hospitals, those that are under low pressure tend to have higher costs. Those that are under more pressure due to some characteristics maybe that we see in the same table, such as higher Medicaid share of days, something like that, they're under more financial pressure, and those hospitals tend to keep their costs down. Those that are under pressure, even amongst the teaching hospitals, then, would tend to maybe to have a little bit better Medicare margin.

DR. BORMAN: If you did this distribution across the high-, medium-, low-pressure, say, for our category of other-than-major-teaching-hospitals, would the percentages shift out in this similar way, roughly 50/20/30?

DR. STENSLAND: For the other non-teaching, there would be a smaller number in the high-pressure group, for the non-teaching.

DR. BORMAN: Just ballpark order of magnitude difference?

DR. STENSLAND: The ones that are not teaching, about 30 percent of those are under high pressure, the

teaching about 50 percent under higher pressure, not including the Medicare aspect of it. They're under pressure to make money off of Medicare, and of course the teachings make a lot more money off of Medicare than the non-teaching.

DR. BORMAN: And then, just a process, and I always worry when I wander into anything that's close to statistics and economics, given the firepower in this room. However, we do -- in this and other chapters, we've made this wonderful beginning down the road of trying to define things that describe the efficient deliverer, or efficient provider element, whatever, and we're doing that through a criterion reference process. We say that we think these things describe it if they have one or two or three or whatever of these -- sort of a composite criterion reference thing.

Is there a role at some point for looking at this in sort of a multiple regression kind of way, in that this is a very descriptive kind of way of doing it? Ultimately, some of these things that we identify as being perhaps characteristics of the efficient provider may in fact vary together and, at least in my simplistic understanding, that's where some value of some sort of regression or

multivariable process or something could come into play. Is that something that, in the future, we can think about, look at, whatever?

DR. STENSLAND: I think that some people have tried to come up with their measure of who's a good hospital using some regression techniques where they come up with one number: This is your index number of a good you are. This is all your decision, but my feeling, or the feedback I got from you all, was that that might not be the way you look at it, in that you don't want someone to be seen as a great hospital just because they have really low cost or just because they have really high quality. You want someone to be efficient only if they're good on quality and on costs.

So, I think it's because it's not just a cost metric, I think we might want something with more than one final number saying whether you're good or bad. You might want to have to perform well on more than one basis.

DR. BORMAN: Just to quickly clarify my question, because I'm not sure I conveyed it very well.

We may define a number of things, characteristics, but that -- and they may in fact -- some of them may in fact be demographic. I mean, a lot of the stuff we are looking

at here does relate to urban, rural, teaching, non-teaching, demographics may not be quite the right word, but sort of a ballpark. And some of those things may in fact track together.

So, for example, if it's an urban major teaching, is that the thing that dominates as opposed to some other characteristic that you come up with here? I'm not trying to talk about a composite single number. I couldn't agree with you more in your answer.

DR. KANE: I have two questions, and I think one is around the draft recommendation.

I just want to clarify, so, we're talking maybe that there's 1 or 2 percent that the quality incentive payment would come out of existing rates.

And then, would the IME be -- are we recommending the IME one percent be in addition to our be part of the funding of that? I wasn't sure how those two were supposed to go together. That's only one question; I have one more after that.

MR. HACKBARTH: What we've said in the past is 1 to 2 percent, and we have not addressed explicitly whether in this case we are talking about a 2 percent for the base

program and then another additional point from IME, or whether IME replaces one of the percentage points.

DR. KANE: Do we have a sense -- maybe I should ask Peter -- what's a meaningful quality incentive to really make hospitals feel that this is worth responding to? Is it 2 percent? Is it 3 percent? Is there any work done on that to address what's a meaningful amount?

MR. BUTLER: First, I'm supportive of quality payments. Any percent makes a difference. We are competitive organizations and when you put scorecards in front of us, we respond, even in the absence of any payment at all, the core measures have moved along nicely in terms of what's occurred. So, any percent makes a difference and 1 or 2 percent sounds small, but it's a big number. And it's the right size to get started. It's plenty.

MR. HACKBARTH: Those were the points that I would emphasize.

When you're talking about institutional providers like hospitals that operate on narrow margins, 1 or 2 percent can be a significant amount of money. But I would underline Peter's second point is that this is our starting point. We've suggested beginning relatively small and that

you may want to increase that number over time, but as a starting point go with 1 to 2 percent.

DR. SCANLON: It's one or 2 percent taken from the whole, but in terms of the hospital that's performing well, it could be 4 or 5 percent in terms of the reward.

MR. HACKBARTH: An excellent point. And so, this is creating the size of the pool, and then the gains for an individual hospital depend on its performance, and also how you write the formulas for distribution of the money.

DR. KANE: We would be leaving all that to Congress to decide how to do.

MR. HACKBARTH: There was a mandated report to CMS -- two years ago, was it, Mark? Maybe even less than that.

CMS developed a very lengthy report detailing its advice on how to distribute the money. We were required to review that report, as I recall, and we basically said we agreed with the general approach that they've outlined.

DR. MARK MILLER: If you will remember a few years back, we had principles about how to design this and lots of that was reflected in that report.

DR. KANE: My second question goes back to slide nine, the one before this.

For the top performers, the ones under high-pressure and high quality, it looks like they achieve a 2007 margin of 0.5 percent. What is their projected point, 2009 margin? Because, in talking about the update, we're talking about what would an efficient provider need for an update in light of their projected 2009 margin?

DR. STENSLAND: I didn't take these hospitals and project what their specific margin would be in 2009, given 2010 policies. But given the breakdown, it's going to probably, on average, about a half percent lower, so maybe a minus 0.5 percent. That would be a guess.

Of course, there's no great precision to this, because we are trying to project what their cost growth would be. There could be future differences in the Congress in terms of what their updates are or rules that change the payment. It's going to be about breakeven, but if it's plus one, minus one, that's certainly within the realm of our error.

DR. KANE: So if we're trying to think about what the projected margin of an efficient hospital provider in 2009, we're talking breakeven or possibly a little below breakeven, in considering what the update should be.

DR. STENSLAND: Yes, these relatively efficient providers, that's true.

DR. KANE: Okay. Thank you.

DR. STENSLAND: There's still going to be a distribution amongst these folks, but at the median hospital, it will be about breakeven.

DR. KANE: I understand. We're used to dealing with those single-point things.

MR. HACKBARTH: I would remind people that we are still in the clarifying round. So, if you have a quick clarifying question, ask that now, and if it's something more complex that requires a lot of dialogue, let's hold that for a second round.

DR. CHERNEW: I will be, I think, very clear in clarifying. The first point is, the Medicare margins include the fixed cost or the capital that gets allocated; that's part of the Medicare margin. You have a terrific discussion in the chapter about these two hypotheses about the relationship between private margins and Medicare margins, because all of this is Medicare margins and not total margins. I just want to clarify that I understand, when that discussion is all said and done, what you think

about the relationship between the private and the Medicare margins. So these are basically yes/no questions.

The first one is, you believe, I think, that hospitals in difficult, non-Medicare markets hold their costs down without sacrificing quality -- at least many of them do -- and therefore have Medicare margins, because they're holding their cost down because of private pressure, but that's reflected in better Medicare margins, and quality is not worse. Is that --

DR. STENSLAND: That's generally true. And the quality, not worse -- I would say there's at least a set of them that do that without hurting their quality.

DR. MARK MILLER: Wait a second. As long as we're doing this lawyer style, he said market --

DR. CHERNEW: I'm sorry. I didn't mean -- that's economist style.

DR. MARK MILLER: He said a market. I think we're looking at individual hospitals when we look at the pressure.

DR. STENSLAND: That's true. That's true. And that's a good clarifying point, because I would say it's not uniform across the market.

DR. CHERNEW: Right, so if non-teaching hospitals are doing better under more or less pressure, there might be differences in how they're paid. That's helpful.

The second question, very similar, was, I think what you're saying is, on balance, relatively generous non-Medicare payments allow hospitals on average to maintain adequate access, and even expand, because all of your stuff says hospitals of adequate access and are expanding -- they can do that despite the negative margins, the negative Medicare margins, presumably because they're having more positive non-Medicare margins, and that's what allowing --

DR. STENSLAND: Right.

DR. CHERNEW: -- that's what's reconciling the positive access stuff with the very negative Medicare margin stuff.

DR. STENSLAND: Right.

DR. CHERNEW: Is that what you're base -- okay. I understand now.

MR. GEORGE MILLER: A clarifying question along the same issues. You deal with high-pressure, non-Medicare margins versus low-pressure non-Medicare margins, greater than 5 percent of whatever, looking at the chart.

How much did you take into consideration the percentage of those different groups with Medicaid population?

And then, second part of that question with the Medicaid is, what impact would the case-mix index have on those issues, because it would seem to me that, anecdotally, if a high margin/high-quality hospital that did not have OB services, an example, and didn't accept Medicaid patients, that case makes index would be higher, because, conversely, a low-performing hospital that had OB services and took Medicaid patients would then have a lower case-mix index, because having a baby has a lower relative rate for a case makes index and would drive that hospitals case-mix down lower, and then, therefore, by definition, would be a lower-efficient hospital, but by the case-mix and not necessarily because the quality of services?

DR. STENSLAND: Let me start with -- the case-mix I have in the paper is the Medicare case-mix. So, that's just the case-mix for Medicare patients, the expected resource use for Medicare only. So, the OB -- there's not going to be much of that in Medicare, so it's not going to affect the case-mix.

MR. GEORGE MILLER: There wouldn't be any, would it?

DR. STENSLAND: Somebody might be disabled and there's a location --

MR. GEORGE MILLER: Yeah, disabled. Okay.

DR. MARK MILLER: On that point, I took his question as, and if I'm wrong, I'll immediately get out of the way. I took his question as, case-mix isn't driving somebody in the low-cost or high-cost column. We are adjusting case-mix out of all of these costs.

DR. STENSLAND: What we did is we --

MR. GEORGE MILLER: Because this is only Medicare case-mix and not overall --

DR. STENSLAND: Right. But we did look at hospitals and say, okay, let's look at these ones that are really under pressure to do well in Medicare, meaning between -- when you add up their donations and their private profits and their Medicare profits or losses and their uncompensated care, these folks aren't doing that well, so they need to do pretty well on Medicare, okay?

When we looked at saying, okay, well, who are those folks? What are their characteristics? Their

characteristics, they did tend to be hospitals that, a, had more Medicaid shares, and, b, had a lower case-mix. There could be a lot of other factors that are related to case-mix that might be driving this; it might not just be case-mix. You could imagine a scenario where you would say, oh, well, maybe the high case-mix hospitals are the ones that have fancy services, maybe they have the premier bypass operation in town, and so, maybe they're able to negotiate higher prices on the private side and maybe that's -- you can see that maybe it's that market power that these guys with low case-mix don't have that's driving it. Maybe it's not just case-mix. But in terms of Medicaid, it does look like, if you have a lot of Medicaid patients, that's tough, and then you have to look somewhere else for your profits.

MR. GEORGE MILLER: Yeah, but if they don't have Medicaid patients wouldn't that have an impact, although it wouldn't be in this number here, but if they had a higher percentage of Medicaid patients would that not distort those numbers, because in theory, Medicaid at best pays what Medicare pays, and in many cases don't because of their location?

DR. STENSLAND: I don't think it would does

distort those numbers, but high Medicaid may mean lower revenue per case, may mean more pressure to constrains costs, and then may mean lower costs.

MR. GEORGE MILLER: And higher Medicare margins.

DR. STENSLAND: And higher Medicare margins. We would see that whole strain.

MR. HACKBARTH: So, George, if you look at page 27 in the chapter in the notebook, that's the table that summarizes.

MR. GEORGE MILLER: Yeah, that's I have -- I have it open.

MR. HACKBARTH: So, I think this is consistent with what I hear you saying, that if you have a somewhat larger share of Medicaid, you're a little bit more likely to be in that high-pressure column.

MR. GEORGE MILLER: Correct.

MR. HACKBARTH: That means, because you're under a financial pressure, you're more likely to reduce your cost and therefore do well on Medicare.

MR. GEORGE MILLER: Got it.

DR. CASTELLANOS: Just two. One is this very simple one we've asked before.

I think we've talked, what makes the difference between a high quality/low-cost hospital. When we drill down, it's cooperation between the medical staff and the administration. That's another avenue, and it's not addressed here and I think we need to address it. I think that's important, it's something we want to do with the delivery system reform.

The question I really want for clarification is, in the material that you sent out, on page nine, there was a chart showing increased Medicare outpatient services growing like anything and the fee-for-service and hospital discharges stable. We all know that there's a tremendous a shift to Part A to Part B and there's a tremendous savings for that. When we look at Part B, and I brought this subject up last time, we kind of always look at the physician side of Part B, and I think we really need to think globally of Part B. By that, I mean physicians only account for 38 percent of that, and a lot of that increase in Part B is -- so, I just think we need to think globally of it and I'm just curious what you think about that.

DR. STENSLAND: Just from a technical standpoint, if you added up at the hospital outpatient, which is growing

pretty rapidly, and the physician, which is growing pretty rapidly, that some of those two things are going to grow pretty rapidly.

DR. CASTELLANOS: They're growing pretty much the same, almost parallel in the outpatient department, if that's your question.

What I think is -- if you look at the volume in the outpatient and the hospital on page 10 of our materials, it's about 3.5 percent, and on the physician side -- it's somewhere around 2.9 in the physician column.

MR. HACKBARTH: I wouldn't infer from similar growth rates that exactly the same forces are at work in physician and hospital outpatient. Some of them are the same but not all of them are the same.

DR. REISCHAUER: You've provided some characteristics of hospitals under pressure and not under pressure. Do we have similar kinds of breaks for efficient providers, I mean, sort of average size, geographic location, both state and central city, suburban, rural, teaching, the number of hospitals competing with them in the market area, dependence on Medicare and Medicaid? Just to sort of understand whether these are really a peculiar set

of conditions and it would be difficult to replicate it more broadly.

DR. STENSLAND: I can add that in there. I don't have the specific numbers with me, but in general it's a wide group of hospitals. You see some brand names that you would see in the U.S. News & World Report as the best, biggest hospital. You see some that are in markets with lots of hospitals. You see some in markets where they are the only big hospital. You see some small hospitals, you see some rural, some urban. It might not be exactly proportionate, but it's widespread. A lot of the ones you would suspect you are going to see that people talk about as being an innovative hospital or that show up on CMS's list as the best care for cardiac services -- you're going to tend to see those a little more often.

DR. REISCHAUER: I think just making that point verbally would strengthen the analysis in the chapter.

DR. STENSLAND: Okay.

MR. HACKBARTH: My recollection from previous years' analysis, Jeff, is that we have looked at efficient hospitals and compared them to other institutions in their market, and done market-based comparison, and found that,

within a given market, the efficient hospitals look somewhat different than they're nearby competitors. Am I remembering that correctly?

DR. STENSLAND: That was a little different analysis, and this is efficiency, good quality, low cost. That was what we looked mostly just at cost, and we did see these low-cost hospitals tended to have lower costs than their neighbors, lower cost growth than their neighbors. So it was an individual hospital phenomenon. It wasn't like everybody in the market was at this place.

MR. HACKBARTH: Underlining -- this class isn't -- all hospitals doesn't necessarily mean all the hospitals in a given market. There's variation within markets on the cost dimension, at least.

DR. STENSLAND: Right, and the quality.

MR. GEORGE MILLER: Just on that point, do you have the characteristics of those hospitals, where they're located? Are there similar characteristics of those types of hospitals?

DR. STENSLAND: We have them. I don't have them right here, but I'll make the description in the chapter about how they are diverse across types of hospitals:

teaching/non-teaching/size/geographic region, that kind of thing.

MR. GEORGE MILLER: Yes. I'd like to know what they do if there's some characteristics germane, wherever they are. Does that include the rural hospitals that would be in that category? are.

DR. STENSLAND: There certainly are some rural hospitals in there. The one hospital that we don't put in here because they're paid differently is we don't have critical access hospitals.

MR. GEORGE MILLER: Critical access. I understand that.

DR. STENSLAND: But the other rural hospitals we have in here, and we certainly see some that do well on both cost and quality.

MR. GEORGE MILLER: Thank you.

MR. HACKBARTH: Okay, so that was the clarifying round, which should be very clear I guess, judging by the length of it. Are there other questions for round two?

MS. BEHROOZI: It's sort of like a round 1.5, because it's sort of following on what Bob and George were asking about. It's sort of a question and a suggestion.

First of all, in round two, we're supposed to say what we like and then what we don't like. So, I like the recommendations, just in terms of the focus of the chapter. I guess it's along the lines of, sometimes you find what you're looking for.

So, the question of what the characteristics are of the hospitals that are efficient, that are low-cost and high-quality, that would be the best group, but even just focusing on the low-cost group. There were questions about the kind of immutable characteristics or whatever, the things that they can't change, like location and profit/not-for-profit status, that kind of thing. But I'd be interested also in the kind of things that they can change, that they do have control over like -- I think Ron was kind of approaching this sort of issue -- employed physicians.

Last year, sometime, there was an article in the New York Times about the public hospitals, the HHC hospitals. I think being in that somewhat efficient group, low-cost and high quality and they really zeroed in on the employed-physician component. So, I wonder if that and other components are ones that we could look at so that we can start setting some of these standards, or things that

hospitals can aspire to, as opposed to changing their geography, which they can't. So that was one thing.

The other thing that I guess I'm a little troubled by is the posing of the question on page 29 and then, to a certain extent, on page 31, as whether -- if Medicare would pay hospitals more, hospitals would then seek less from private insurers and then insurers would lower premiums for employers and consumers. Not in this world. That's just not going to happen. So, I don't think it's really useful to pose the question that way. I think it goes the other way, directionally: If payment is inadequate, and you do refer to studies that have demonstrated that is contrary to the hypothesis that you set out to prove in the paper, if Medicare and Medicaid payment, if government payment, is inadequate, then hospitals say they are forced to seek higher payment from private payers.

So, I'm a little troubled by saying that, oh, if Medicare paid more, then there would be an offset from the private sector to Medicare and Medicaid that's not going to happen. So, I think it's a question of adequacy and what happens when payment is inadequate.

DR. MARK MILLER: We kind of knew that. We were

just trying to lay out the way to think about the issue.

You're referring to the part of the chapter where we've gone through and done kind of the cost-shifting point. We thought this was an important thing, because this is in the environment.

And to Mike's question early on, it's really a question of how we think about it relative to lots of other people in the world. Lots of other people say costs are immutable and therefore we have to go to the private to get this difference. Our fundamental point is, cost actually gets influenced by what you're being paid.

The point we were try to make with that question is, do you really think this will happen if Medicare simply raises its rates? I think that the point goes on to say that, in the 90s, when you saw this reduction, it wasn't because Medicare raised its rates and the private sector lowered its; It was because the private sector and Medicare both were putting fiscal pressure on hospitals. But we will be clear in our rhetoric here.

DR. KANE: I think that issue needs to be talked about, though, because I can tell you, at the state levels, when the private payers -- and they constantly complain

that Medicare and Medicaid don't pay enough and therefore there's this huge cost shift. They hire consultants that have literally a boilerplate that blames all of the cost increase on the private sector on the private sector, on the Medicare and Medicaid program, rather than the fact that they are not negotiating effective rates.

So, I think you need to make that point. I think we need have a good discussion of the fact that we really need high pressure from the private sector in order for hospitals to keep their costs down. It's not because Medicare and Medicaid are underpaying that the private sector is paying higher rates. It's because they don't have either the market negotiating power or the willpower or whatever it takes to lower the rates they pay.

It's a recurring theme in almost every state I've worked in that it's all the fault of Medicare and Medicaid that private rates are high. I think that theme needs to be addressed head-on.

DR. STENSLAND: However we pose the question, even if you oppose the way Mitra did it, the empirical analysis is still the same, because the question is, okay, these hospitals are in tough shape. So, are the ones that are in

tough shape -- are those the ones that then the private insurers are willing to give more money to? Are those the ones that are getting the big private insurance rates?

It doesn't look like that's the case. It looks like, when they're in tough shape, they have lower costs and then they end up doing okay on Medicare, but they're kind of forced to push their costs down.

We look in markets where we have at least some anecdotal data of who's getting the highest rate from the private insurers, it looks like it's more like the people that have the market power to get the highest rates as opposed to the people who are in the most financial need. It doesn't look like the insurance companies are allocating their money based on altruism as opposed to based on some sort of desire to keep the must-have type hospitals in their network.

MS. BEHROOZI: It also becomes a federal-state shift. If Medicare's rates are inadequate, then hospitals in distress that can't get higher rates from insurers end up running to the statehouse where they might have some influence to seek distressed pool money and that kind of thing.

But yes, I know that you don't think that that happens, but, like I said, I think posing the question that way makes it very rhetorical and not advancing the argument.

MR. GEORGE MILLER: I like the chapter and I like the way it was worded and flowed.

I do have a question in the analysis for 2009. If you took into consideration the current financial market crisis that we're in with the increase in unemployment, the impact of loss of job-related health care, increase in costs for borrowing -- as an example, I think I read somewhere or someone sent me a letter saying that interest payments this year from July to September is 15 percent more than it was a year ago. Were all of those factors taken into consideration with the increased cost? And then, therefore, increased demand for health care services by those who either lost their insurance or are unemployed -- have you taken those into consideration? Increase in their ED visits, how that may have impacted the cost considerations for 2009. It could be a little late in the game, but I'm just asking the question.

DR. STENSLAND: I just want to be clear: We're not making any projection on overall total margins for all

players. We're only making the projection for Medicare. So, we're not factoring in things like fewer people have insurance so you'll have more uninsured that you're not collecting from. That will affect the total margin. It's not really going to affect your Medicare margin.

MR. GEORGE MILLER: Medicare margin, right.

DR. CHERNEW: [off microphone] The Medicare margin is better.

MR. GEORGE MILLER: It's going to make the margin better.

DR. STENSLAND: Well, there's kind of offsetting factors here. When we talk about the cost growth assumption we have, we don't assume -- we say there's no real clear reason for us to think that the path will necessarily change from where it is right now in the low fours, to four to five range, and the reason being that there's some things that might push costs up. Interest rates are higher. Pension funds have been depleted it. They may have to put some more money in their pension funds. So, there are some things pushing costs up. But on the other hand, we hear anecdotal reports of the hospital saying, now, we're under more financial pressure and we're tightening our belts. Some

people actually use that phrase. That might put costs down a little bit, to the extent that the hospitals are tightening their belts, maybe restricting some hiring, restricting some raises. So, we're not sure which one is going to have the bigger effect. Is it the ones that are pushing costs up that are going to have a bigger effect than the factors that are pushing it down? So, we don't make --

MR. GEORGE MILLER: By definition, they could eliminate services, which could create an access issue. And so, have we taken that part into consideration? If you're going to use anecdotal information about tightening their belts, they could drop services to tighten their belts.

DR. STENSLAND: It's possible. We haven't seen -- so far, the trend of the last 10 years has been upping the number of services you have, upping the number of hospitals. So, if that dips, it is possible. There is also the twist, though, of, will the access to Medicare patients go up or down? If the non-Medicare sector has less insurance, if they demand services less, there may be more capacity left over to serve the Medicare patients, whose insurance status and financial considerations haven't really changed. So, I'm not clear whether Medicare patients' access will be

going up or down a.

MR. GEORGE MILLER: By definition. Okay.

MR. BUTLER: One statement just on the data, and I think I said this last month: The IME reduction, just to clarify, is not a 1 percent reduction, really it's about a 20 percent reduction in IME payments. And so, major teaching hospitals under this recommendation would get about a zero increase given the market basket. It's about zero for major teaching hospitals next year, when you take the market basket and you pull out the IME, that's about where it is. And it takes them into negative territory in terms of the projected Medicare bottom line; correct?

MR. LISK: That's about right.

MR. BUTLER: Okay. That's just a comment.

I would say two things related to the chapter. One is that there is a lot of reference to the robustness of the performance in 2007. It was a high total profit margin year for hospitals; that's facts. There's a certain lag effect in this chapter. If you look at the third quarter of the calendar year of what we were just in, the data shows that actually total margins were negative. And admittedly, a decent piece of that is due to the investment income and

what has happened in the market, but operating performance has also declined, in part because of bad debt charity care increases and in part because of softening and volume, and data that I have even shown that Medicare admissions themselves are actually down in the third quarter versus the third quarter of the previous year. That's just kind of a factual update on the financial health that we ought to be aware of.

Secondly, there's reference to -- it uses the word erratic access to debt and so forth. Really, since September, there's been virtually no access to speak of. There was, as pointed out here, a little blip up where some debt got out of the market. But as somebody who's trying to go to the market and so forth, it's pretty much frozen right now. Now, that could change and it could change significantly, but it is a complicated issue and it's a supply and demand issue. But, as a single A-rated institution, you have to pay as much as 8 percent right now. It sounds like a good deal if you want to buy one of these bonds. Part of that is a mismatch between supply and demand where the Lehman Brothers of the world, the hedge funds of the world, a lot of people that were buying these bonds just

aren't there. So there's no customer to sell them to in the short run.

My point is, you have a message here with Moody saying, a lot of hospitals seem to be doing okay and they will have access. I think that is not only fluid, it's really kind of a big issue and I think were not only delaying but stopping projects in some cases. So, as you go to the Hill, just try to be as current as you can with respect to that issue.

Finally, I support the recommendations. I would say that, with respect to the IME and the language on the rationale where it says, these funds are provided to teaching hospitals with no accountability for how they are used. I would like to see that softened. It suggests that you handed out money and they're not accountable organizations. If we said something to the effect that the IME money is not connected to the expected -- there aren't expectations about how it's used -- or some language just has a little bit different tone, I think that would be a more positive way of stating it.

MR. HACKBARTH: We've used an hour on this, which was our allotted time.

The one issue that I thought we might take up in the third round is the cost shifting issue. But in view of the fact that we started 15 minutes late, I'm kind of thinking that the more prudent thing to do is to proceed and go to the votes on this. So, unless I hear some strong objection on that, that's what I'd like to do.

So, we've got recommendation one up. All those opposed to recommendation one, please raise your hands? Abstentions? All those in favor?

Recommendation two. Opposed? Abstentions? In favor?

Okay, thank you very much.

Next is physician services.

MS. BOCCUTI: Good morning. This presentation on physician services will cover two main topics. First, I will be presenting a summary of our analysis. So following our update framework, I will focus on indicators of payment adequacy, such as access and volume, expected cost changes, and then recommendations for your review and vote.

Next, Ariel will discuss ways to change payments for expensive imaging services and he will talk about equipment use standards and you will be reviewing and voting

on a recommendation for that.

I also want to note that although the chapter for this material will include a section on ambulatory surgical centers, we've designated that topic for the next session to allow adequate time for you to focus on the issues.

As you recall, MedPAC sponsors a phone survey to obtain the most current data possible on beneficiary access to physician services. We competed this year's survey of roughly 10,000 people just this past October. We survey both Medicare and privately-insured individuals age 50 to 64 to assess the extent to which any access problems are unique to the Medicare population. I have just a brief summary of the results on this slide.

Looking at rates of people being able to schedule timely appointments with their doctor, we continue to find that most beneficiaries do not regularly experience delays getting an appointment. Seventy-six percent of those who tried to schedule a routine care appointment reported never experiencing delay, increasing to 84 percent for illness or injury appointments.

We also found that Medicare beneficiaries fared a little bit better than privately-insured individuals on

these appointment measures.

We found that about 6 percent of Medicare beneficiaries and privately-insured people reported that they were seeking a new primary care physician during the year. So among -- well, that low percentage, I want to note, I think says that the vast majority of people are satisfied with their current primary care physician. Among the 6 percent looking for a new PCP, Medicare and privately-insured people reported about the same experience; that is, about 28 and 26 percent respectively said they experienced problems, some big, some small.

Access to specialists was better for both groups, particularly Medicare, where we found a larger share of Medicare beneficiaries reporting no problems compared to privately-insured individuals.

Also analyze these results by race and found that access problems are more likely for minorities for both Medicare and privately-insured individuals. MedPAC will continue to track this question closely in future surveys.

Mitra and Jennie raised some issues that related directly and indirectly to income effects on access, so Hannah Neprash and I examined data from our survey on this

question. I note that methodologically, our data on incomes do not include asset information. Therefore, it's difficult to compare measures on wealth, say, among Medicare beneficiaries, many of whom are retired, to the 50- to 64-year-old population. Also, the low number of categorical variables on the demographic portion of the survey do not adequately distinguish levels for our purposes. So for these reasons, we really only saw a couple clear correlations and I will note them here.

First, consistent with most published research, we found that lower-income individuals in both Medicare and privately-insured populations were most likely to say that they did not access care when they thought they needed to.

The second finding that is interesting is that when we were talking about looking for a new primary care physician -- that is the 6 percent that I talked about -- we found that for Medicare beneficiaries, their likelihood of looking for a new PCP was equally likely across incomes. But in contrast among the privately-insured individuals, the lower-income ones were more likely to say that they were looking for a primary care physician.

So a possible rationale for this finding is that

among the privately-insured people in the survey, those with lower incomes were more likely to be switching jobs and therefore switching insurance and switching potentially the physician network and so having to go find a new physician. So that the person that goes a little, Jennie, to your question about right before they're eligible for Medicare and I think that speaks to that.

So looking at the results of our survey, we found that other organizations have presented analogous results in their surveys conducted in prior years, namely the Center for Studying Health Systems Change, AARP, and CMS with the CAHPS fee-for-service survey. We also found that in certain local markets, access rates were really similar to national rates, even in areas that were suspected of problems.

In other research, we found that emergency department visits by Medicare and privately-insured individuals has remained steady over the last decade, and the share of physicians signing participation agreements and taking assignment continues to be high.

Also, I will note that AMA recently released a report card of national health insurers and found that overall, Medicare performed better than most insurers on

administrative measures like, for instance, timeliness and accuracy of handling claims.

Looking at cumulative changes in the use of services per Medicare beneficiary in fee-for-service, you can see that the growth has continued to increase each year but has slowed a little in recent years. Growth has also been slower for E&M and major procedures relative to the other three categories.

We analyzed claims data from two large insurers and compared their fees to physician services to Medicare fees. Looking at the far right bar for 2007, Medicare rates were 80 percent of private rates averaged across all services in geographic areas. This percent is just one point lower than the previous year.

So on to the second part of our adequacy framework, which is changes in costs for 2010, CMS's preliminary forecast for input price inflation is 2.4 percent. Within that total, CMS sorts the inputs into two major categories, physician compensation expected to increase by 2.8 percent, and physician practice expense by 1.9 percent. Calculated from BLS statistics, our analysis of trends and multi-factor productivity suggests a goal of

1.3 percent across all sectors.

So before we discuss the overall update recommendation, I'm going to shift gears for a moment and review policy changes affecting primary care, some of which are completed or in progress and others that have not yet been adopted.

So combined, two changes in the physician fee schedule have increased payments for primary care by about 10.6 percent. The first is the 2007 review of the fee schedule's work RVUs. On average, CMS increased the work RVUs for primary care services by about 26 percent. For the most frequently billed E&M service, the work portion constitutes a little bit more than half the total payment for that service.

CMS also changed its method for determining practice expense RVUs to include new data and improve accuracy and transparency.

CMS and the RUC have also undertaken an ongoing review of potentially mis-valued services. As you may recall, MedPAC recommended that CMS consider payment adjustments when signals such as rapid volume growth indicate potential mis-pricing. In its current screening

process, CMS and the RUC are using claims data to flag services with certain characteristics, like high volume growth, changes in site of service, and other items. But note because of budget neutrality constraints, all services that do not see a decline as a result of this review would increase. So primary care is likely to see an increase from this review, but other services will, too. So far, the PE and/or work RVUs for about 140 services have been changed or are in the process of being reviewed.

CMS is also underway with its medical home demonstration that was established by TRHCA and increased in dollars through recent legislation, MIPPA. I will note that while specialists who focus on chronic conditions may serve as medical homes, it's expected that primary care physicians will be a major source of medical home participants.

I will note two other policies that are not yet adopted by Medicare. The first is the payment adjustment you recommended in the June 2008 report. As you know, this would increase payments for primary care services that are furnished by practitioners who focus on primary care. In this chapter, we discussed a 5 or 10 percent increase, but the level of the increase was not in the explicit language

of the recommendation.

And finally, pending your vote today, the imaging equipment use adjustment could reallocate money away from expensive imaging services towards all other services, including primary care. Ariel is going to discuss that in just a few minutes.

Also last month, I reviewed some of the bonuses that physicians may receive in 2010, so I'm not going to repeat them now, but I can certainly talk about them in the question and answer section.

I also want to mention that we were unable to include an analysis of ambulatory care quality in Medicare fee-for-service because of data issues, but I will remind you that for our 2006 cohort they did see most measures were stable or improving.

So onto the overall recommendation for physician services, and I'll read it. The Congress should update payments for physician services in 2010 by the projected change in input prices less the Commission's productivity goal. So if current estimates stayed constant, this would update payments by 1.1 percent for 2010.

Take it away, Ariel.

MR. WINTER: Thank you. Before I start talking about the imaging equipment use rate, I want to address a question that Mike raised at the last meeting. Mike asked how much office-based imaging is done by primary care versus other specialists, other specialties, and to address this question we have a chart on the screen from GAO which was present by Bruce Steinwald at the September meeting. It shows the increase in the percent of total Part B revenue that is derived from imaging performed in the office by a specialty exclusive of radiology, and you can see that primary care specialties derived about 6 percent of their Part B revenue from in-office imaging in 2006. Some other specialties, like cardiology and vascular surgery, were much higher.

As you may recall from our last meeting, there are concerns about Medicare's practice expense payments for imaging services. Rapid volume growth of expensive imaging, such as MRI and CT scans, may be a signal that such services are mispriced. The cost of imaging equipment per service accounts for a significant portion of the practice expense payment for imaging studies. In calculating the cost of equipment per service, CMS assumes that all equipment is

used 25 hours per week, or 50 percent of the time that practices are open for business, and they assume that practices are open 50 hours per week. If the equipment is actually operated more frequently, its costs per service decline, and this is because the fixed cost of the machine is spread across more units of service.

Setting the equipment use factor at 25 hours per week for expensive imaging machines rather than using a higher level leads to higher practice expense RVUs for services that use these machines. These higher payments encourage low-volume providers to purchase expensive machines because they can cover the high fixed costs of the machines even if they are operated at less than full capacity. The diffusion of costly imaging machines may stimulate volume growth. A recent study by Laurence Baker and colleagues found that additional MRI and CT machines are associated with a higher volume of scans.

In addition, there is evidence from a survey by NORC that was sponsored by the Commission that the current use rate is too low for MRI and CT machines. We showed you this table at the last meeting. Since then, we learned of an error in the table, so we have revised the numbers. As

you can see, the revised numbers are higher than CMS's current assumption of 25 hours per week. Although these survey results are not nationally representative, they are representative of MRI and CT providers in these six markets.

Based on your discussion at the December meeting, it appears there is support for using a normative equipment use standard of more than 25 hours per week for expensive imaging machines. A normative standard of 45 hours per week would discourage providers from purchasing expensive imaging machines unless they could use them at full capacity, with some allowance for downtime due to maintenance or patient cancellations. Under CMS's assumption that providers are open 50 hours per week, a 45-hour per week use rate would equate to a 90 percent use rate. In fact, the 2006 NORC survey found that several imaging providers operate their CT and MRI machines more than 45 hours per week, demonstrating that this high level of use is achievable.

If Medicare were to adopt such a standard for costly imaging machines, a key question would be how to define costly. As described in your mailing paper, imaging equipment has a wide range of estimated purchase prices.

We propose that CMS start by adopting a 45-hour

per week use rate for diagnostic imaging machines that cost at least $1 million, which would include CT, MRI, and PET machines. The Secretary should explore also applying the standard to imaging equipment that costs less, such as nuclear medicine cameras, which have an estimated purchase price of $565,000.

Increasing the equipment use rate for costly imaging machines would reduce practice expense RVUs for services that use these machines. At the same time, it would increase practice expense RVUs for other physician services. These higher RVUs would come from lower RVUs for expensive imaging as well as money that would have been returned to the Part B Trust Fund under the policy that caps fee schedule rates for imaging at the outpatient rates.

For illustrative purposes, we contracted with NORC and SSS to model the impact on practice expense RVUs of increasing the equipment use rate from 25 to 45 hours per week for MRI and CT scanners. This model shows how RVUs would be redistributed from imaging to other physician services. The model does not account for the effects of the outpatient cap on imaging payments. Therefore, the actual reductions to imaging payments would be significantly

smaller than shown here.

Based on 2005 volume and the 2008 conversion factor, we estimate that almost $900 million per year would be redistributed to other physician services. This amount would increase if the higher use rate were applied to other types of equipment.

This leads us to draft recommendation two, which reads: The Congress should direct the Secretary to increase the equipment use standard for expensive imaging machines from 25 to 45 hours per week. This change should redistribute RVUs from expensive imaging to other physician services. We would say in the text that CMS should start by adopting the higher use rate for equipment -- imaging machines that cost at least $1 million and that they should explore applying the standard to imaging equipment that costs less.

And here now are the implications for both recommendations one and two. Regarding spending, relative to current law, these recommendations would increase federal program spending by more than $2 billion in the first year and more than $10 billion over five years. Under existing law, the SGR calls for a 21 percent decrease in payments for

2010 and smaller reductions in subsequent years.

Regarding beneficiary and provider impacts, these recommendations would maintain providers' willingness or ability to serve Medicare beneficiaries. They would increase beneficiaries' Part B premiums and coinsurance, and recommendation two would redistribute practice expense payments from expensive imaging to other physician services.

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

MR. HACKBARTH: Thank you. Could I ask a clarifying question of Cristina, and it has to do with slide 9, Cristina. Could you explain the 10.6 percent again, what that means? I missed that.

MS. BOCCUTI: That's the combination of the PE and the RVU changes that have been underway. So the RVU, with the E&M codes that went up when we looked at physician work, especially for the codes where there is a lot of physician time -- and it is for primary care services.

MR. HACKBARTH: So does that mean that due to the combination of work and practice expense changes, primary care fees have increased 10.6 percent?

MS. BOCCUTI: Yes. Right, Kevin? Yes. And so

that's -- through 2009. So not all of these are today, but through the payments that will have been received from 2009. So the PE was really -- it went through from 2007 to 2009 to fully implement those PE changes. So using that percentage added to the work RVU percentage. That's for primary care.

MR. HACKBARTH: Just one other related question. Refresh my recollection on the primary care modifier and our recommendation there. In particular, remind me of the magnitude of that adjustment.

MS. BOCCUTI: We discussed both a 5 percent and a 10 percent and we looked at some impacts for both of those. But in the recommendation, we just said an increase in the language. Does that answer your question?

MR. HACKBARTH: Yes. That's what I wanted to get out. So if it were -- let's just for the sake of discussion say it were the 10 percent version. So for a physician that met the Secretary's test of a primary care physician getting the modifier, would that be additive to this?

MS. BOCCUTI: Yes.

MR. HACKBARTH: So for those physicians meeting the --

MS. BOCCUTI: Right, because that hasn't been

adopted. So the 10.6 is what is being adopted.

MR. HACKBARTH: So if those policies alone, these things that have already happened plus our recommendation, which we are reiterating in this report for a primary care modifier, the combined effect would be a 20 percent increase in fees for primary care physicians -- the ones meeting the Secretary's test.

MS. BOCCUTI: If it were 10 percent, but --

MR. HACKBARTH: If it were 10 percent.

MS. BOCCUTI: Yes.

DR. MARK MILLER: But also, in our recommendation it is targeted. This is throughout the --

MS. BOCCUTI: Right.

MR. HACKBARTH: Yes. So I'm saying for the physicians that meet the Secretary's test.

MS. BOCCUTI: And those, right.

MR. HACKBARTH: Right. And then, if in addition to that a physician, one of those primary care physicians participated in the medical home and qualified for the lump-sum per beneficiary payment, that would be on top of the 20 percent. Refresh my recollection on what the RUC's recommendation was for the magnitude of the capitation

payment.

MS. BOCCUTI: What's in the demo language that CMS has released, they have two tiers and two risk categories. So $50 per member per month is not far off from what it averaged together. I don't have those numbers right in front of me, but --

MR. HACKBARTH: Yes, and it would be difficult --

MS. BOCCUTI: For some it is above 50 and for lower, it's more in the 20s.

MR. HACKBARTH: Obviously, my point here is that I think a number of us are concerned about primary care and the pace of improvement for primary care relative to the magnitude of the problem and none of what I just went through alters my concern, my personal concern about that. But I think it's important for people to keep in mind that things are happening, the 10.6 percent. I'm hopeful that the primary care modifier which we are recommending reiterating this time will happen in the not too distant future, and then we've got the medical home pilot in work. So it's not a totally bleak picture. It's not as rosy as I would like it to be, but there is some stuff happening.

Now clarifying questions, other clarifying

questions.

DR. DEAN: The productivity goal of 1.3 percent. where does that number come from, the 1.3? How is that calculated?

MS. BOCCUTI: That's the number that is used from the Bureau of Labor Statistics, multi-factor productivity. It's a 10 year moving average and it's non-farm work -- non-farm, yes, professional multi-factor productivity analysis. And that is used across sectors. It's not specific to physician offices.

DR. DEAN: I guess that was my question. It really has no specific relationship to medical practice?

MS. BOCCUTI: Only to the extent that if you think about physician offices as being a business, a small business or how that works, that it's using the numbers that are as closely related to an office business, but not necessarily a medical business. They are not excluded from the analysis, but they're within it.

MR. HACKBARTH: Let me just say a word about the productivity adjustment in general, and this is for the benefit of the audience as much as the Commissioners. The productivity adjustment that we include as part of our

update discussion is not intended to be a measure of the actual productivity change in the physician's office or in a hospital or in a skilled nursing facility or any other provider. It is instead a way of linking our payment to Medicare providers to the broader economy, and in particular the pressures felt by the taxpayers, the people who have to fund the payments to physicians and other Medicare providers.

Taxpayers in general, the vast majority of them work in very competitive markets, often facing competition from foreign imports from low-wage countries, and so they are under relentless pressure to improve their productivity. Regrettably, that pressure for many Americans comes in the form of not just reduced wages but lost jobs, lost health benefits, lost retiree benefits. And these are the people that are paying the Medicare expenditures that we talk about.

So the productivity adjustment is a way, admittedly a crude way, of saying that the people who provide Medicare services ought to feel some of the same pressure that Americans in general feel, and frankly they're usually Americans that have lower incomes than physicians

and many other Medicare providers. So it is not an effort to estimate physician productivity or anybody else's productivity. It is a way of applying some pressure to Medicare expenditures.

DR. DEAN: I guess maybe the trouble is semantics more than numbers, because to me productivity implies that you are going to increase your output for a given number of inputs or you reduce the costs. And it seems to me, as we talked about before, so much of the direction we're trying to go is to really change the way medical practice is carried out. Much of this, if we change in the direction that we would like with more focus on coordination and collaboration, a lot of those measures are going to go down and are going to look wrong -- are going to move in the opposite direction of productivity. So maybe I am hung up on the term rather than the bottom line, but it just seems to me it's a model that doesn't apply and doesn't move us in the direction we want to go.

MR. HACKBARTH: Let's set aside the semantics for a second and focus on the substance. I agree with your basic point that the way we want to define productivity for physicians in this case is not just we want them to churn

out more stuff. We want them doing the right things that improve care for patients in general and Medicare beneficiaries in particular.

So how do we accomplish that? I don't think it's by giving a higher update to all physicians by eliminating a productivity adjustment. We do it, rather, by changing how we pay physicians, and there are two types of changes. One is the change that we just talked about with changing the relative fees for primary care versus other services. But equally or more important is changing the payment method, and medical home would be an example of that. The driving notion behind medical home is to try to provide compensation for services and activities that are important to patients but not paid for through the fee-for-service payment structure.

DR. DEAN: I think your original point that what we're talking about is the 30,000 foot decision about how much goes into the pot, and really what a lot of us are troubled by is what happens after it gets into the pot and the distribution system and it gets all muddled up in terms of that.

MR. HACKBARTH: I'm sorry for taking so much of

your time here. Let me go back to the clarifying questions.

MR. EBELER: Cristina, I'd like to take you up on your offer to elaborate a little bit on the two other adjustors that were included in the 2008 Medicare bill. I think they related to the PQRI incentives as well as the technology adjustment.

MS. BOCCUTI: Sure. There is the PQRI, which was for 2009 and 2010. That's going to increase -- I think that increased from 1.5 to 2 percent. That is, of course, a voluntary program and those eligible and who satisfactorily submit the quality information that is requested will receive the 2 percent bonus in 2009 and 2010.

The other one is the e-prescribing bonus, and that also is voluntary and that will go through 2009 and 2010, and then the bonus ratchets down in subsequent years to the point -- I have been numbers here, but I am guessing it is 2013 where it starts to be a negative if you don't submit in electronic prescribing. Then there could be a negative affect on the payments.

MR. EBELER: But in 2009, if you do it, you get another two points, is that correct?

MS. BOCCUTI: Right, yes. Ron is nodding. But

notice that that is a payment on all your allowed charges, so it's not just those associated with the prescription. It's on all the services that you give -- assuming you do it adequately and satisfactorily.

DR. KANE: I had two questions, the first one on the medical home demonstration.

Do we have a sense of the status of the implementation of that, and then the timing of that? If it meets at some level of performance that we're hoping for, how long would it take for these demonstrations to be converted to actual program opportunities or practice, because I think we've talked a little bit about whether a demo is a right mode and would it should be a pilot.

I guess I know we have all these great ideas out there, but I don't have a sense of how long it will take for them to be actually available generally to the program. So what's the status of the demo now? And they actually contracting with medical homes? And how long do we think that will take before it becomes something we can do more broadly?

MS. BOCCUTI: CMS is proceeding and they've put out a lot of information. They've got to the payment levels

that Glenn asked about. They've gotten to the requirements of the medical home.

I think what they're waiting for a little bit right now might be some clearance from OMB where as soon as they get that, they're quick to be going and telling the States, because there's going to be eight States or areas that can apply to participate. So that's the next thing that I think is coming up. And once that is announced, then the process of having them apply and getting that started up should be beginning. I think that's going to be in 2010.

DR. KANE: And then how long do they have to run for before we think that the lessons are adequate for program change?

MS. BOCCUTI: Well, from the start date, which may be towards the end of 2009, the demonstration should be three years. That's what is in law as best I can recall. And so there should be some evaluation reports probably midterm at some point. I don't think it's going to be until the whole thing is over that we will start to hear how it's going.

So I think you need a three-year window to really think about how changes in that kind of practice may, in

fact, improve health and lower costs so that you have some time, particularly with chronic conditions, to see that change.

I think in our chapter, we talked a little bit about the need to have this as large as possible so that the time frame for the cycle is as short as possible. So when there's results, we will have enough sample size to really make sure, to verify that that is really happening.

So what I'm saying is if you have a change --

DR. KANE: I understand.

MS. BOCCUTI: Okay, you've got it.

DR. KANE: I understand that part, and I guess my final question is so they come up with the report and let's say the evaluation says, wow, this is really great. Then how long does it take to become part of the program? And how many demos actually become programmatic features of Medicare? I'm just trying to say, how effective -- where are we going with a demo and do we stop there or should we be pushing much harder for -- I mean, we didn't do an evaluation of private fee-for-service. We didn't do an evaluation of MA plans the way they're currently structured. So this is going to be delayed. I'm sorry. I know this is

a clarifying question, but if we're talking seven to ten years before we see anything like this going into the program is what I'm concerned about. And I just wonder if we should pat ourselves on the back that this is a demo that might happen next year or whether we should say, this is just not going to be anywhere near fast enough to get us where we want to go. That's sort of a clarifying question.

MS. BOCCUTI: I will let Glenn -- I think Glenn has --

MR. HACKBARTH: Well, I sure don't have anything to say that's going to relieve your concern about how long these things take. One of the reasons that we recommended a pilot as opposed to a demo was to at least truncate this cycle time somewhat by allowing the Secretary to act based on the results without having to go back through the legislative process, which basically takes at a minimum a year to get all the way through.

And second, we recommended a significant increase of the scale of the demo/pilot so that you would have the statistical power to discern results more quickly.

They did increase the size of the project in MIPPA, but they did not turn it into a pilot as I recall,

did they?

MS. BOCCUTI: No, you're right.

MR. HACKBARTH: Yes, so it's still a demo. So we're talking about a significant amount of time still. At the end of the day, the really critical thing is going to be what sort of results are required to determine success. If what you're looking for is definitive evidence that medical home reduces long-term costs, that's a ways out into the future because good care for diabetics may not show up immediately in terms of cost savings. It may improve quality, but not reduce cost that quickly. There are some chronic illnesses were you might get a quicker payback. So that's a problem.

At some point, somebody, ultimately the Congress, is going to be decide, could this be justified on a basis other than long-term savings? Could it be justified because we've got a primary care crisis and we need to shore up the primary care system, even if it costs somewhat more? Could it be justified because of quality gains, even though we are not sure exactly what the long-term cost-effect is?

So I think rather than allowing this seven or eight or ten-year process to play out, somebody is going to

have to say, what the decision basis for a go/no go on medical home? That is, of course, something that MedPAC can come back to at some point.

DR. STUART: Just a clarifying comment on this. We've had -- in a number of contexts, we have talked about the differences between pilots and demonstrations given CMS's powers under the latter. But there is precedent for a hybrid, if you will, which is where a threshold point on some performance measure is specified in the law that creates the demo. And then if that threshold point is passed, then the Secretary is supposed to implement this.

The one that I'm most familiar with is the influenza vaccination demonstration that was developed in the early 1990s. The threshold point on that was that unless it was possible to prove that the benefit would not be cost-effective -- which is impossible to do and the evaluator did not show that it was not cost-effective -- then the Secretary was to make the benefit available. Now that language may be a little squirrely, but there is clearly some room here for MedPAC to evaluate the possible thresholds and then to recommend that Congress implement a version of that type of demonstration.

DR. KANE: I have one more clarifying question. I'm sorry. It's a quicker one, though.

On page 17, on the increase in the equipment use rate slide, is it budget neutral, because if the minus 7.9 percent is not real because it's actually not that much because there's already a cap on it, then are we actually, by kind of getting out from under the cap and redistributing, is it budget neutral? Or is it actually going to add to the -- it's just unclear to me how that works out.

MR. WINTER: It adds money. It adds money to the physician fee schedule. That's what this slide is trying to capture --

DR. KANE: That's what I thought.

MR. WINTER: -- if you look at the last two sub-bullets. Some of the money comes from money that was already within the physician fee schedule, but some of it comes from money that currently is taken out of the physician fee schedule and returned to the Part B Trust Fund. Some of that money would now stay within the physician fees schedule. We've not modeled how much comes from each pool, but there is some new money that would go

back into the physician fee schedule.

MR. EBELER: I just want to follow up on Nancy's point and Bruce's comment. There is nothing that prevents the policy community, MedPAC, or the Congress from acting before a demonstration is complete. In particular, I think when you look at this demonstration, I think part of what we are trying to learn is how to implement this. There's a lot of outcome things you want to look at, but exactly how does one implement a monthly payment to a fee-for-service practice for a certain group of patients -- I think as we get a year or two down the road, just getting some confidence that the agency can do that is a huge hurdle here, just to be thinking about. So it's another way to look at this.

DR. CASTELLANOS: First of all, Cristina, great job, and Ariel, good job, and Cristina, I appreciate your taking my phone calls.

I have a couple of clarify questions. One is I'd just to clarify that the Commission in the past has said we're not satisfied with the current physician update mechanism, and I'm sure that we all agree to that. I would hope we do.

Ariel, have one for you. It's a simple one. The equipment use rate, what equipment is that going to be applied to and to which providers is it going to be applied to?

MR. WINTER: This is sort of open for discussion. We've not specified exactly which types of equipment in the recommendation, but in the text, what we have right now is that it should be applied immediately to equipment that costs -- with an estimated purchase price of more than $1 million, and that would cover CT, MRI, and PETs, and that the Secretary should then explore applying this to equipment that costs -- that is below that $1 million threshold. And so where you set that threshold is somewhat subjective, and so it's open for your discussion and for --

DR. CASTELLANOS: Which providers is that going to be applied to?

MR. WINTER: We have not done an impact analysis by specialty, but if you look at primarily who's billing for the MRI, CT, and PET codes, it is going to be IDTFs, that is freestanding imaging centers, radiology, and then to a smaller extent specialties like neurology, orthopedic surgery, and cardiology.

DR. CASTELLANOS: How about to the hospitals?

MR. WINTER: This would not apply to the outpatient PPS. It would not apply to hospital outpatient departments, only to physician fee schedule providers.

DR. CASTELLANOS: Why?

MR. WINTER: The outpatient PPS has a very different methodology for setting the relative rates. It's based on charges reduced to costs, whereas in the physician fee schedule, you have lots of different assumptions that are driving the RVUs and one of those assumptions is this estimate of how frequently machines are used, and that currently is 25 hours per week, which was not an empirical estimate. It was sort of a default assumption that CMS began using when they implemented practice expense -- resource-based practice expense RVUs. And so that is what we are talking about here now.

DR. CASTELLANOS: Cristina, one of the things that bothered me last time and again it bothers me this time, and Jeff started out saying we're going to talk about payment adequacy indicators and we're going to discuss it among all our discussions today. Then I come to the physician side and we look at access and we look at volume.

There are other indicators that you and I need to talk about, and we need to talk about, and one is costs. Obviously, we don't have a cost report on physicians, but we have mandated unfunded Medicare issues that force the physician to buy equipment and to provide services. The big one now is e-prescribing. We're going to have to get EMR. It's not going to be ready in one year to buy EMR, get it set up, and do that. We have to upgrade our equipment for that. We have costs for that equipment.

The other issue that we're not discussing, and I brought it up earlier in our administrative, is quality care. We need to talk about quality in this discussion, too.

I just think when you talk about payment adequacy indicators, these need to be discussed in all providers, not just some providers.

MR. HACKBARTH: Again, I would just highlight what Cristina said earlier about the issues that we had with the data around quality measures that we have used in the past. So in the future, provided those issues can be resolved -- and I assume they will be -- we will go back, as we've done in the past, to having a section on quality in physicians.

MS. BOCCUTI: As I mentioned in the presentation, for 2006 data, which is --

MR. HACKBARTH: We can include those.

MS. BOCCUTI: I'm going to reiterate that. For those measures, and the cohort for 2006 compared to previous cohorts showed an improvement or stable indicators for the majority of the research.

DR. CASTELLANOS: But the unfunded mandates, that is a dramatic cost to the primary care physician and to the practicing physician.

DR. MARK MILLER: Well, actually, on that point, I thought you did address the e-prescribing.

MS. BOCCUTI: Right. So I would say I will put in the chapter --

DR. MARK MILLER: And that was new money?

MS. BOCCUTI: Yes.

DR. MARK MILLER: And it goes on for three years?

MS. BOCCUTI: Yes. So there is a percentage increase in all allowed charges for those physicians who start early up and submit prescriptions electronically.

DR. CASTELLANOS: I'm very familiar with that, but it starts out at 2 percent, then goes down to one percent,

then down to zero, and then by 2014, we get penalized if we don't do it. So we do have to get that equipment and it's not going to get up in a year. It's going to get a lot longer to get up and running in a year, if you have ever started EMR. I am sure you could tell us about it in the hospital setting. It takes a long time to set up that equipment.

But there are other unfunded mandates, too, you know, HIPAA, limited English proficiency, that requires us to spend money if we're going to participate in the Medicare program, but it is not at all considered in any of our cost report.

DR. BORMAN: A couple of questions. Cristina, when I look at slide 8 and we talk about the current forecast of the changes, could you just make sure I've got this correct. This CMS forecast will be potentially adjusted again before 2010?

MS. BOCCUTI: Yes. So that's why we -- yes. The forecast -- what I talked about is what they are today, the forecast for 2010. CMS quarterly revises the estimates.

DR. BORMAN: I just wanted to make sure, because we explicitly sort of say CMS can change the forecast in the

hospital, but we don't say it in the same -- in the analogous part of the physician chapter. So I just wanted to make sure I had that correct.

And then my other question, Ariel, is for you. I've got two related to the imaging. The first is if you look on slide 17 where you talk about the change in the PE RVUs, and clearly the most substantial rises are in other procedures and tests. If you did this calculation impact for change in total RVUs by those big categories and services, do we have any ballpark of what that would be?

MR. WINTER: No, we didn't have our contractor look at the impact by total RVUs. We can try to do some back of the envelope calculations. I'm not sure we will have them in time for the chapter, but we will see what we can do.

DR. BORMAN: I'm just curious about the relative rank order here, and the rest of my commentary about that is not clarifying and I won't go into it right now.

The second part is you have a table that talks in the chapter a bit about the room costs, for example, for the different -- and in an attempt to come at this question of what should be the threshold level for considering this.

Can I just ask, that, does that take into account the contrast agents that might be utilized in those different advanced imaging, because there are some significant differences in that piece of it in terms of anything that uses a radionuclide or an isotope will have higher costs and related to the handling of radioactive material and some of those kinds of things. The supply costs of that are probably a good bit higher than, say, non-ionic contrast for a CT scan. So I just wonder, there may be some point at which we want to take that piece into account and maybe it's at the next tier of deciding, okay, $1 million kind of seems like a good sniff test number. Maybe as we look at the next one, there could be value to factoring in that piece.

MR. WINTER: Okay, and most of those contrast agents are paid separately from the technical component payment. So they're billed separately, unlike the outpatient PPS where in many cases now they are packaged into the procedure payment. So in the fee schedule, many of them are billed separately. If we're talking about the supply that's part of the technical component payment, then that, as you know, it's a separate component of the direct cost. We could certainly consider your idea that we

consider the supply costs as well as the equipment costs.

DR. BORMAN: This is a practical implication. I think the spread between ultrasound and other modalities will grow if you consider the contrast piece, because there really isn't contrast by and large very often in the sonar world.

MR. GEORGE MILLER: Very quickly, on page two of the information about the data analysis of ED and the wait times for whites and non-whites, were did you get that data from? What analysis of that data?

And then secondly, did that data say why there was a difference in wait times?

MS. BOCCUTI: Nancy Ray did some work with the National Ambulatory Hospital Care Survey, NAHCS, and that information gave her the wait time disparity that was discussed in the chapter. I don't believe that more information on reasons was given.

MR. GEORGE MILLER: But it was empirical data and not an opinion, a survey --

MS. BOCCUTI: That is correct. It is from a data source and it is not a survey subjective. It is from a data source.

MR. GEORGE MILLER: All right. Thank you.

MR. HACKBARTH: Any other clarifying questions? Any other questions at all? We're not going to have time for a round three, so let me just see those hands again. We've got a lot. Well, I suppose the sooner we get started, the sooner we will get finished, right, so let me see the hands on this side again and we will just go down the row.

MR. BUTLER: Just a comment. We have alluded to e-prescribing a couple of times and we also read in the paper the stimulus package could have $25 billion for electronic health records and these kind of things. As you invest in health care IT, the productivity pick up and the gains are large around variation in care, utilization, and other things. They are not in the doctor's office.

My point is, in a way, we have, I think, given not enough attention to the impact of IT in the physician's office. You're never going to have greater productivity, I don't think, because of it. So it's more, Glenn, as we go forward in health reform in our June report, is that another opportunity to comment on this particular issue, because I think it is a very, very significant opportunity, but also an additional burden and a big part of the productivity

question.

MS. BEHROOZI: Thanks very much, Cristina and Hannah, for looking at the patient income question.

So on page 17 of the paper in the slides where you talk about people who didn't access care and you sort of give a list of reasons and list cost concerns among them, that might be an appropriate place if you could to add the observation about --

MS. BOCCUTI: We will. We weren't able to get -- we're still completing it, so we will certainly be putting that in.

MS. BEHROOZI: Great. And just a comment on that, that we look at supply of physicians as an indicator of payment adequacy and sort of use the term access, like do patients have adequate access to physicians? Are there enough of them? And then you note in the paper that it's only 6 percent of people who are looking for a physician. But that number is becoming, I think over time, and maybe it's not so evident right now but it will become more evident as the economic crisis that we keep talking about, how it hits providers, hits individuals, people who are retired and their 401(k)s are wiped out are now suddenly

low-income people who weren't previously.

And as the cost-sharing burden rises -- I support the recommendation, I support paying physicians a little bit more, but that means that patients themselves have to pay a little bit more and more of them can't afford Medigap policies and more of them no longer have their employer-provided retirement health care supplement. I think we need to start thinking about access more broadly because only 6 percent of people are looking for a new physician, but on average 8 percent, you said, of people did not seek care when they thought they should have.

I don't know how much of that is because of cost concerns, but obviously you're finding some evidence that cost concerns have a lot to do with it. And seeing that twice as many African-Americans -- 14 percent as opposed to 7 percent -- are not seeking care, to the extent that race is a proxy for income, I think it's something that we should start paying more attention to as we go forward and not just physician supply being determined by -- I'm sorry, access being a question of physician supply.

MS. HANSEN: Mitra, you and I didn't talk about this, but I think the points that you just made are there.

First of all, again, thank you, Cristina, for doing this segment. I can only, frankly, reiterate every single comment that Mitra just made, and perhaps this does go to Peter's point that maybe this whole -- in our June report, whether or not the whole aspect of looking at the impact of the beneficiary could be perhaps fuller about the share of costs, because here the impact on the recommendation. And I'm delighted that we are going to look at greater access to services. But the concomitant impact is the payment both for the premium as well as the copayments. So if we could really begin to start showing that, because as we talk about, say, the impact to the providers of what percentage increases are theirs, the Part B premium, as you have cited in previous reports, has just astronomically increased in the past five years. So what does that really mean for any patient and especially a beneficiary that has limited income to begin with, let alone what Mitra pointed out.

So I guess my bottom-line request is putting in the content, but then thinking if we could in the June report really have an understanding that while we buff up appropriately for one group, the concomitant increase may ironically reduce access on the other side.

MS. BOCCUTI: Speaking for this chapter, we do try to -- we have a chart this year that sort of shows the premium and the spending differences. So I think we've added somewhat to that extent and we'll add this information in.

I think what you raised about dropping Medigap policies is something that I wish we could track immediately. It's very hard to get to that kind of detail on the beneficiary survey. But I think I'll talk with staff. I think that would be an interesting thing to look at, because that does have an access implication and an income implication and employer, yes.

DR. DEAN: Just a couple of things. First of all, in response to the overall recommendation, I guess obviously I'm conflicted about it. I think I'm comfortable or can certainly live with the bottom-line recommendation. I obviously have some real concerns about the methodology. I just am really bothered, as I guess I have already stated, with the idea of productivity. There is a specific rural aspect to that that some of us, first of all, are in areas where there is a limited number of patients and we simply can only see the patients that are there. The thing that

makes this formula even worse is that we are required to add equipment to cover a broad range of services that we know is not going to be used efficiently. It just has to be there because we have to have it when people come in.

So I think applying the sort of conventional idea of productivity to settings like where I am in really has a negative implication.

I would be much more comfortable in the long run to use some -- to take the productivity element totally out, like I said, and maybe were talking about semantics more than anything else, but to replace it with some kind of performance or quality kind of measure that would encourage people to do the right thing rather than to do just more of what they've been doing.

MR. HACKBARTH: The rural issue, I just wanted to make sure that we have on the record what is done for rural physicians. As you know, there are some special payment adjustments.

DR. DEAN: When you get to the distribution part of it, there certainly are some things that compensate.

MR. HACKBARTH: Off the top of my head, first of all, there's a floor of 1.0 on the work RVUs, which was --

MS. BOCCUTI: That's been extended, that's right.

MR. HACKBARTH: Right. And then there are at least two 5 or 10 percent adjustments for --

MS. BOCCUTI: There's the HPSA bonus, which is 5 or 10 percent. Now, there was another bonus that was added in MMA that I think has expired, which I think is what you're thinking about.

MR. HACKBARTH: So there's one that's targeted at physician shortage areas. Kevin, can you help us out here?

MS. BOCCUTI: He's nodding.

DR. HAYES: (off microphone) It's a bonus, which is 10 percent -- [inaudible].

MR. HACKBARTH: So in keeping with what's become a boring theme of mine is that if there are particular problems, whether it's primary care or rural, the way to deal with those problems is not a generalized increase in the update factor for everybody but targeted programs. And, in fact, a lot of those targeted things are being done.

DR. KANE: Just to kind of follow-up on my comments about the medical home, I really feel that primary care is in a state of crisis and something that's going to take five or ten years to work out. It's just really not a

viable option.

I guess it makes me think more about how do we innovate and what kind of recommendations are we making around innovation. It seemed that expanding drug coverage and innovations on the private sector within plan administration, nobody did an evaluation of how that was going to work out or even found out ahead of time whether it was doable administratively. It just happened. And it just shows that if you have political will to solve a problem, you just do it and you don't spend a whole lot of time applying evaluation technology, which takes way too long. And I'm a researcher, but I really know it takes forever often to get a convincing answer out of data.

So I think some types of innovation, I think we kind of have to move beyond this randomized clinical trial standard and get into what problems do we have to solve here, how big are they, and how fast do we have to act. And I would like to see something not necessarily in this -- I mean, I am supportive of the recommendations, but they're just a little tiny drop in the pond. We really need to sort of move a whole ocean, and I'm very concerned that this just keeps getting treated as, oh, well, it's out there and so

we should pat ourselves on the back and say we're solving this problem because we're not.

Primary care is really in a huge state of crisis and I think even the private sector is doing medical homes as we speak. What can we learn from them? Do we really have to wait for a demonstration? Let's get moving on this.

I agree with Tom 100 percent that productivity, the way it's measured, fee-for-service productivity is the wrong way to measure -- even though that's not what our productivity adjustment is for, but that is not the measure of what a primary care doctor does. It doesn't even come close and it's time to fix it, and it's time to fix it at the same level of urgency that I think that it was time to fix the prescription drug problem.

I think I would like to see this commission take a stand at that level of urgency rather than say that something might happen someday in the future once we know all the facts, because that's just not the right standard of evidence for this kind of problem. Otherwise I'm very supportive of it.

MR. HACKBARTH: We will have another opportunity to talk about some of these issues later on in the year

where we talk about training and the number of people going into primary care will come up there, as well, and we can consider some additional policy tools.

DR. CASTELLANOS: First of all, the overall update, I'm very appreciative of. I think that's good.

The productivity, again, my comments are the same as Tom's and as Nancy's. It's not in place in the physician community or in the physician's office, but philosophically it does make sense. It would be nice maybe to get something in the health care sector, but I think we need more work on it, like Nancy said.

The big point I wanted to make is the same thing as Jennie made and Mitra made and Peter made about access to care. Peter mentioned hospital admissions are down. Well, I'm in private practice, and I'm going to tell you, patients are not coming in. I have cancer patients that are not coming in. It's a reflection of the economy. I don't know how to handle that, but there is a problem with access and I think it's related to the economy. The uninsured or the poorly insured or the Medicaid patients, they just don't have access. I'm not sure if that's in our bailiwick, but I think it needs to be at least discussed.

The reason the ER visits are down is people are now going into walk-in clinics. They're going to Wal-Marts and like that where they have nurses or nurse practitioners in extended care taking care of these people at a much more reasonable rate.

We are seeing cracks in the wall, and I'm telling you, where I'm practicing, I see a lot of cracks in the wall. I see a lot of my older patients with cancer, people I've been watching, that are missing their appointments, and they're missing it because they cannot afford it.

DR. SCANLON: I am fully supportive of the first recommendation. I have concern about the second. The concern relates to the idea of making a distinction for equipment based upon the cost of the equipment. The concern relates, first of all, to the issue is I don't know the consequences of that, what's going to happen in terms of access to what I might think of as important sort of equipment because of this kind of a change.

I'm much more comfortable sort of with the idea that we make this change in terms of increasing the utilization assumption based upon information about what utilization is like in the world. It's not a question of

going for the level of utilization across the country. We're working off of medians and means and making a 25- to 45-hour increase. So I think we can have that as the standard in terms of when typical utilization is much higher, we need to raise the utilization assumption.

The other two things that sort of motivate me to think about a change like this is that this is very reminiscent of certificate of need, where we used to have dollar thresholds. Lo and behold, the manufacturers discovered, take on this belt, take off this whistle, and I can get right under the dollar threshold and then I've got a great market for my equipment. So I want to avoid repeating that experience.

I'd also like to avoid repeating the experience we had with the practice expense rollout initially. We had two resource-based practice expense roll-outs. The first one got rejected by the Congress because there was -- in part because there was a very aggressive assumption about equipment utilization. The Congress's instruction was to HCFA, go back and do this over again but reflect actual experience. I know that because they said, GAO, you have to sit over there and look over their shoulder and make sure

that they're reflecting actual experience.

So I think that I would be much more comfortable if we're talking about using data on experience to make this change. And we can give priority, saying look at equipment that costs more than $1 million first. Get the data on that to make sure that we're not sort of under estimating the amount of time that it's been used and work you way down. But we should be basing these things on actual experience and data collection. This is one of those things, again, where we should be flying blind. We should be collecting data to make sure that we can set the payments right.

DR. CROSSON: Thanks, Glenn. First of all, I'd like to compliment you both on the report. When I got to the 80th page, I said to myself, I'm not sure in the last five years that I've seen a comprehensive report of this nature, and I began thinking about proposing something called the Commissioners' Comprehensiveness Award.

[Laughter.]

DR. CROSSON: No, but seriously, other than taking on the SGR again, you've pretty much covered every issue and done it very well and I thank you for that.

I have support for the second recommendation, but

I have concern about the first recommendation. It has to do again with the question of the applicability or the wisdom in this particular part of Medicare payment of applying the productivity number. I've talked about this before. I talked about it last year.

This is not to say in any way that I have a lack of concern about the cost of care, the impact of that on beneficiaries, on the Medicare program, or that I believe the update system is the way to fix the problems that need to be fixed. Certainly, dealing with the SGR as a flawed update mechanism is one of those. Ultimately, I do believe beyond that delivery system reform and payment reform will get us to where we want to go. But we are doing with the update at the moment.

The concern I have particularly is that the issue of productivity -- and I understand that we have a terminology issue here and the like. But the thought of it seems to cut differently when applied to institutions versus individuals. And even within the practice of medicine, I believe that there is a difficulty in achieving continued productivity when an individual person is working only with their time and their hands and their minds.

So there may be a concern here that the notion of applying productivity to the physician update actually runs counter to the issue that we've been discussing with respect to trying to apply more resources to solve the primary care problem, to build on the medical home issue, et cetera.

I agree with Nancy that I think the efforts in place, and we have been working on this for two years and have done very well, I think, may be falling short of the nature of the problem that we are facing with respect to primary care. So I have a proposal.

The proposal is actually to alter draft recommendation one and to make it parallel to the draft recommendation that we made an hour or so ago on hospitals. As you may remember, we voted on and approved the recommendation for hospital increases which increase the rate by the hospital market basket concurrent with implementation of a quality incentive payment program. The notion there was to redistribute, in this case, the hospitals who were producing higher quality.

What I'm going to propose here is that we actually take the previous recommendation, which is on slide 9 in the bottom section, the recommendation not yet adopted, and

apply that in much the same way we did in the hospital sector. So the recommendation would read, the Congress should update payments for physician services in 2010 by the projected change in input prices concurrent with implementation of a payment adjustment for primary care services furnished by practitioners who focus on primary care services, adding teeth and reiterating both and adding teeth to the previous recommendation. That's my suggestion.

MR. HACKBARTH: Let me ask a couple of clarifying questions, Jay.

So you're emphasizing the parallelism with the hospital recommendation. So the hospital recommendation is full market basket concurrent with pay for performance, which means a reduction on full market basket to fund the pay for performance.

DR. CROSSON: My understanding is you were talking about it as the size of the pool earlier, that the size of the pool remains the same but there is a redistribution.

MR. HACKBARTH: But in terms of, as we discussed earlier, the guaranteed update that a hospital gets is not full market basket, but full market basket minus the amount that goes into the pay for performance pool?

DR. CROSSON: That's correct. So this is keeping the size of the pool equivalent but redistributing within the pool.

MR. HACKBARTH: So what you envision is that the average physician would be guaranteed not the full input price increase but less than that, as is true of hospitals?

DR. CROSSON: I'm not sure who the average physician here in this case. What I'm suggesting is that --

MR. HACKBARTH: Well, it would be the increase in the conversion factor would be less than the full input price increase.

DR. CROSSON: What I'm suggesting here is that the productivity reduction not be placed, be removed, but instead there would be a redistribution of the money as we suggested in our recommendation last year. I'm not sure how to think about the average physician in that. I'm thinking about the size of the pool and the fact that there would be further redistribution to primary care.

And we haven't talked about, and I'm not suggesting a particular number for the size of that. I think that would be something probably left to the Secretary's discretion.

MR. HACKBARTH: Now, in your lead-in, it sounded to me like your problem is with the productivity language as much as anything. What if, as alternative, we were to say 1.1 percent, which is the projected increase, minus productivity, drop the productivity language? Is it 1.3? I misstated.

The projected input increase is 2.4 percent and the productivity adjustment is 1.3 percent. So based on the current projection, the increase in the conversion factor would be 1.1 percent.

DR. CROSSON: I think we have two concerns here. Number one has to do with the issue that I think productivity, if you extended over time, as a principle in the individual practice of medicine separates physicians by specialty in terms of their ability to do that. The more institutionalized, the larger the practice, the more things the physician can bill for, presumably the easier the productivity improvement is.

DR. MARK MILLER: Let me just say one thing. In addition to all of the discussion back and forth on the productivity is about the taxpayer and all the rest of it, another misunderstanding that keeps coming into this

conversation, and I've let it go, but there is this assumption that it's specific to each physician. The productivity assumption is across all physicians. Even the whole discussion is it's really not about productivity in that sector. But just even setting that aside, if productivity is improving under radiology, imaging, those types of areas, that's the way the update is being looked at.

So you keep bringing the argument back to, but for me or this physician, how can this be the case? It will vary by physician.

MR. HACKBARTH: So this discussion is about how much to increase the pool of dollars for physicians in view of economic distress for patients and their having increasing problems of affordability, in view of the very rapid increase in Part B premiums. In view of those considerations, how much should we increase the size of the physician payment pool? That's the issue at stake in the update.

DR. CROSSON: Right. And I think that if we had the discussion on that basis without, in my mind, the complexity of the productivity issue, I think that would be

a different discussion. We would bring different issues to the table. Isn't that likely?

MR. HACKBARTH: That's what I'm trying to get at by asking, what if in this particular case, because of the hesitation that some Commissioners have about the use of productivity here, what if we say, okay it's 1.1 percent. Our recommendation is for a 1.1 percent increase in the conversion factor.

DR. CROSSON: I think I would be perfectly willing to engage in that discussion if we're --

MR. HACKBARTH: We're having it right now.

DR. CROSSON: Well, we are, yes.

MR. HACKBARTH: What is your bottom-line?

DR. CROSSON: Whether I like it or not. Whether I like it or not.

[Laughter.]

DR. CROSSON: However, then I think we have to have a basis for arriving at the 1.1 percent. And if, in fact, we have a set of facts or principles that help us arrive at that, then I could very well see myself agreeing to it or agreeing to some other number.

MR. HACKBARTH: I think that the facts are on the

table. Ongoing rapid growth in Medicare Part B expenditures. Ongoing rapid increases -- even more rapid increases, as I recall the data, for Medicare Part B premiums for seniors on fixed incomes. Growing affordability problems for Americans in general, Medicare beneficiaries in particular. And we're dealing with a well-compensated part of the population. To me, those are the salient facts. How much should we increase the size of the physician pool?

DR. CROSSON: I guess the question is whether the primary care portion of the physician pool is being compensated to the point where new physicians are willing to enter that part of the pool.

MR. HACKBARTH: I'm with you on that and we've made recommendations. I'd be happy if part of your proposal is to have another recorded vote on the primary care modifier as a way of highlighting our sense of urgency about that. In fact, I'd be happy to add language to the text. I'd be happy to write the language for the text underlining our sense of urgency about doing that as a step. It's not a solution. It is a step. But it's something that can be done quickly, unlike medical home and some of these other

things.

DR. CROSSON: You know, there are two issues here. I understand that. One is the principle of the thing and is the applicability of productivity here. And the second one is the size of the pool. And I have to admit that I was influenced in my thinking today with respect to the size of the pool by the fact that the hospital pool, under the same economic circumstances that you described, the hospital pool was, in fact, not reduced by the productivity factor. Had that not been the case, then honestly, I think I would have felt differently.

DR. BORMAN: Thanks. Again, strong work on the chapter. I share some of Jay's highest-level concerns in terms of sort of the final point in the discussion here. And Glenn, in response to your question of is it more comfortable to have a specific number, I think, frankly, for me probably the answer is yes. I supported a similar recommendation last year. My sense is we keep banging on some of the same concerns about physicians, and not through any fault of the Commission or its staff or anyone else, we are making limited, at best, progress in some of these areas. And so I'm a little bit reluctant about being on

record on continuing in supporting that particular methodology. So that would be where I stand on that part.

The comments I would like to make really relate to some degree about balance and consistency and unintended consequence avoidance, if at all possible, and they would be several.

The first is that I would like to see us think about -- move some of our shift to thinking about rewarding thinking, because if we're moving to a comparative effectiveness delivery system, we need to reward thinking regardless of who does it, whether they're primary care physicians, anesthesiologists, pathologists, orthopedic surgeons, or just whomever they are. I would encourage us to be a little bit careful about not considering rewarding thinking by everyone, because what that will subtly send the message is that we want people doing some rather high-risk things to patients whom we're not rewarding for thinking, and I think, frankly, that's not a message that we care to send.

Secondly, I would ask, Cristina, you did a lovely job in, I believe it's slide 9 of the things about the policy changes for primary care, and I would ask that that

material be incorporated into the chapter, just in a sense of balance, because I think we do talk about urgency and so forth, but we fail to document that some actions have indeed been taken and are playing out, and I would appreciate that consideration of that material going in there.

When we look at the imaging impact on PE RVUs, I absolutely support this recommendation, but I am concerned that the greatest positivity goes to the categories of other procedures and tests where we've already expressed some concern as a Commission within those about pricing accuracy. So that was part of my reason for asking, do we know about the total RVU impact, because my suspicion is for at least some subset of those, PE RVUs far exceed the work RVUs. But I'd like to see how it plays out and what the relativity is here. But I support it. That's something that can be done in the next phase of the work, but I would raise that concern, because frankly, my guess would be that we liked the part about rewarding E&M services, and I personally like to see major procedures for once get a positive something out of anything, because if you look carefully at many of the other interventions, a consistent at least small winner or substantial loser in many of these things has been major

procedures and there is a point at least where a subset of those, the 90-day global nondiscretionary kinds of things, we need to make sure that we are preserving access to those in a timely fashion by good quality practitioners.

Then that does bring me to another point that in the background, I'm aware and some others I know of the Commission staff certainly and other people are aware that there is some potential of thinking about just relooking at updating this major category system. It's a very helpful one for us in our deliberations here at the Commission and how staff presents this material. I think there are some real issues as practice has evolved about what really defines a major procedure, other procedures, or tests, how we attribute these things. And I think that it will help us in our pricing accuracy discussion to encourage a refinement of that Betos process.

Then just my last comment would be just to touch on the unintended consequences piece. I certainly am a fan of all the good things an electronic health record can do for all of our patients, and this needs to be about our patients. I do think, and we touched a little bit last time in the disclosure and public site discussion, I would point

out that on the e-prescribing side, we do just need to ask that appropriate protections about privacy and security be part of that process, again, particularly in my world, the most common kinds of things I prescribe are narcotics. There's a huge potential for abuse there. And sort of dealing with that, I would just like to know that the safeguards are indeed there because we are clearly committed to going down this road to the point of negative or disincentives in income relative to that. So I would ask that those things be part of that conversation. Thanks.

DR. MARK MILLER: On a very narrow point, I do think we have some work going on on the Betos refinement, is that correct, so you will see something on that.

MR. HACKBARTH: I have Mike and Bob and Nancy, and let's just do a time check. It's 12:15. We were scheduled to end the morning session at 12:15 and begin the public comment period. For logistical reasons having to do with the building management, we have got to break for lunch at 1:00, so we've got 45 minutes to complete this conversation and also knock off ASCs. So obviously we're going to have to come back to Jay's proposal and have some more discussion about that. So I'd just ask people to keep in mind we're up

against the time lines.

DR. CHERNEW: First, I like the chapter and I support the recommendations. I'll try and make three quick, hopefully not too cryptic, points.

The first one is, several people around the table have suggested that primary care is in crisis, and if you would have asked me, I would have believed that primary care is in crisis, so I don't dispute that at all. I think there's been some academic work suggesting that. I find it curious that in reading the chapter there's no tone of that crisis. In fact, there's this completely different tone which suggests that there's some issues as to what's wrong with our measurements in the chapters, and because I'm wrong about a lot of things, I'm willing to accept the possibility that primary care isn't in as bad a crisis as I otherwise thought. But there does seem to be a difference in tone between the view that primary care is in crisis and the tone in the chapter, which is access is basically okay.

The second point that I'd like to make -- and I think that requires looking at our measures and broader thought of that.

The second point I want to make is recommendation

one, I think, is really a recommendation about the update for essentially non-primary care services and things like that, because as has been pointed out repeatedly, we deal with primary care elsewhere. So this is really setting the bar for what we're paying one group of providers because the other group of providers are getting all the things that Cristina put up on the slide otherwise, and so I think that's just an important way -- when you see this isn't the only aspect of payment, this is really what is setting the bar for that one group of services, that at least affects my thinking about it.

The third point I want to make, which I think is the most important one, is in general around here, we tend to think that when payment rates go up, access goes up. And the reason we think about that is because we are living in a world where we think that patients are insured. And so if you want to increase access, you increase what providers are paid.

Unfortunately, if you're a world where providers aren't insured -- patients aren't insured, when you increase payment rates, access goes down because the patients have to pay some of that. And that's a complete change in thinking

about how you think about access. So every time we argue there is a problem, there is a crisis, we need to increase access and we're going to do that by paying providers more, in fact, what I think we're often doing because of premiums and out-of-pockets is access is getting worse for those people, because the problem isn't necessarily that providers aren't paid enough, although I think some of them aren't.

So I think the challenge is to reorient our thinking the way it will be over the next five, ten, 20 years to a world in which patients aren't getting their insurance through their employers, where they can't afford Medigap premiums, where access is not going up when we pay providers more but it goes down because they have to pay 20 percent.

Now if we're worried about the people that are underinsured, which I am very worried that people are underinsured, that's a completely separate policy question about adequacy of the Medicare benefit package. And that is a question to have outside of the discussion of payment reform. But I fear in the world of the 2000-and-whatevers that every time we vote to increase payment more, we're voting to decrease, not increase, access.

DR. KANE: Just a very quick comment relating to Jay's issue, and I think Mike started to address it, which is I think we should talk about the pool separately from the distribution of the pool. I think if we just changed that word from productivity to affordability, Jay, would you be happier, because the principle is then not that the physicians need to be more productive but that we have to be responsive to the affordability of the Part B premium.

But then the whole issue of redistribution, I think that's really a separate subject and I wouldn't want to link it as you have suggested into the update or the size of the pool recommendation, but rather talk more about how the pool should be distributed in our separate recommendation. So that was just related to what you were talking about.

In other words, I would support this recommendation over tying that to the primary care problem, which I think is separate and needs a lot of its own special discussion to deal with.

MR. HACKBARTH: Okay. So we need to bring this to a conclusion. Let me start with the last step first. What we will do is have a final vote after lunch on a reworded

recommendation. What I want to spend a few minutes talking about is how to reword it.

Let me start with Nancy's comment. One approach would be to have a recommendation that simply focuses on the size of the pool, does not bring in the issue of primary care, continued that as a separate recommendation, and alter the language in the pool. One approach would be affordability. I think maybe the direct path is just to say a 1.1 percent increase.

For me, I'm not willing to go above 1.1. We will vote and maybe the other Commissioners will feel differently and I will lose, but that's as high as I'm willing to have the recommendation go.

So one approach is separation, focus on the pool with 1.1 in there.

A second is the combo approach that Jay proposed where we would link the two, the primary care readjustment with the pool recommendation. The virtue of that, or a benefit of that would be that would be another recorded vote by the Commission with some new Commissioners saying that we think this is important and it's not just a text box, it's another recorded vote.

A third possibility is that we could have two separate votes, but have another on-the-record vote in support of the primary care modifier. I'm making this up as I go along, as is probably self-evident to you.

Among those options, I guess I would be inclined to go with the third, which is have two recorded votes, one on the size of the pool, one reiterating the primary care modifier on the size of the pool as opposed to substituting affordability for productivity. I would just say 1.1 percent increase.

And so that's what I'm going to propose. A quick moment for reactions to that, but I think we just need to bring this to a close with a formal vote after lunch. If there's any vehement objection to that, now is the time to say so.

[No response.]

MR. HACKBARTH: Okay. We will have our formal vote after lunch and during lunch, staff can write up the two recommendations so everybody can see it.

DR. REISCHAUER: Are we going to then have three to choose from?

MR. HACKBARTH: No --

DR. REISCHAUER: We're just going to have the --

MR. HACKBARTH: My recommended package, which is two votes, one on a 1.1 percent increase --

DR. REISCHAUER: There were many heads nodding, and you took that as a preliminary vote.

MR. HACKBARTH: I'm sorry. Let me just reiterate again so I don't confuse people. We'll have a vote on two recommendations. One is for a 1.1 percent increase in the update. The second is the same language as we voted on before for a primary care modifier. Is that clear to the people who have to actually write it up?

MS. BOCCUTI: It might still be on the computer from last year. That wasn't a joke.

MR. HACKBARTH: Okay.

[Laughter.]

MR. HACKBARTH: Before we leave this discussion, I want to go to the vote on draft recommendation two, or Chairman's recommendation two, which is on the screen right now. It's time to vote on this one. All opposed to recommendation two? Abstentions? All in favor?

Okay. The last item before lunch is payment for ASCs.

DR. ZABINSKI: Today, I'm going to discuss our analysis of the payment adequacy in the payment system for ambulatory surgical centers, or ASCs. And as you see through the presentation, if you only examine changes that have occurred to ASC payment rates, you could come away with a very bleak picture of their payment adequacy. But at the same time, if you only examine the empirical trends on the growth in the number of Medicare-certified ASCs, the volume of services provided to Medicare beneficiaries in ASCs and Medicare spending on ASCs, you could come away with a very favorable view of it their payment adequacy. So my goal today is to provide a balanced presentation on these two perspectives.

First, some key attributes about ASCs. An ASC is a distinct entity that exists exclusively to furnish surgical services that don't require an inpatient stay. Also, ASCs that are certified to participate in the Medicare program have their own Prospective Payment System, and beginning in 2008, the payment rates for the ASC Payment System are now linked directly to the payment rates in the Outpatient Prospective Payment System for hospital outpatient departments.

Also, ASCs are a source of revenue for many physicians as the ASC Association estimates that 91 percent of ASCs have some degree of physician ownership. And then, finally, according to the Medical Group Management Association, Medicare payments are a fairly small share of total ASC revenue, about 20 percent, and we would like you to keep this in mind as we consider Medicare's payment adequacy for ASC services.

Now, ASCs do offer some benefits over the sector that is their closest competition: hospital outpatient departments, or HOPDs. In particular, ASCs are more convenient for patients in that they have more convenient locations that HOPDs, patients can schedule surgery more quickly, and they have shorter waiting times for their surgeries. Also, beneficiaries have lower cost sharing on all procedures in ASCs relative to what they would pay in an HOPD. And then, finally, ASCs can be more convenient for physicians because physicians can customize ASCs to fit their needs, and they can also have specialized staffing that is focused on the services that the ASC provides.

Now, although ASCs have some benefits, they also present some concerns, and one concern is patient selection.

For example, research by MedPAC and Rand indicates that Medicare patients in ASCs are less clinically complex than those in HOPDs. Also, empirical evidence suggests that ASCs may be selecting patients on the basis of insurance coverage. For example, 84 percent of ASC revenue comes from patients who have relatively generous commercial or Medicare coverage, but only 2 percent of their revenue comes from beneficiaries who have the less generous Medicaid coverage.

A second concern about ASCs is that the number of ASCs has been growing rapidly, which has expanded the capacity for overall outpatient surgery, and this expanded capacity may lead to overall higher outpatient surgery volume overall.

Now we would like to consider the recent history of the ASC Payment System. First, ASC payment rates have not had a positive update since 2003, which has been required by law. Also, the next positive update required by law does not occur until 2010. In addition, the ASC Payment System was substantially revised by CMS in 2008, and there, first of all, was a 32 percent increase in a number of covered surgical procedures over the number in 2007. Secondly, payment rates in ASCs are now based on the

relative weights from the Outpatient Prospective Payment System. And, finally, separate payments are now allowed for many ancillary services that used to be packaged into the payment for the associated surgical procedure. These ancillaries include surgical -- sorry, imaging services, drugs, implantable devices, and brachytherapy sources. Keep in mind, though, that these ancillaries must be provided as part of a surgical procedure in order for an ASC to receive separate payment for them.

The revised ASC Payment System has reduced the payment rates of the procedures that are most frequently provided by ASCs. For example, out of the 3,400 procedures covered under the ASC Payment System, only 20 procedures account for 74 percent of ASC service volume in Medicare. Of these 20 most frequently provided procedures, the revised payment system has reduced the payment rates for 19 of them. Also under the old payment system, the payment rates for most of these most frequently provided procedures were at or close to the payment rates that they received -- that were under the Outpatient PPS. The rates for these services have declined under the revised system because it now pays for all ASC services at a fraction of their outpatient PPS

payment rate.

Also, these 20 most frequently provided procedures are concentrated in the specialties of ophthalmology, gastroenterology, and pain management services, such as injections to treat back pain. And the ASCs that furnish these frequently provided services typically specialize in one of these three areas. Therefore, these ASCs have lower Medicare payment per service under the revised system relative to what they had under the old system.

The revised payment system also presents some new opportunities for ASCs. In particular, 86 percent of procedures that are covered under the ASC Payment System in 2007 now have higher payment rates under the revised system. In addition, as I mentioned earlier, there has been a 32-percent increase in the number of procedures covered under the revised system versus the old system. Also, ASCs can now receive separate payment for many ancillaries that used to be packaged with the associated surgical services.

And CMS is phasing in the payment rates under the revised system over a four-year period. So for ASCs facing lower revenue per service, this phasing will reduce the adverse effect of lower payment rates while they modify

their operations to take advantage of any new opportunities offered under the revised system.

And ASCs appear to realize the opportunities of the new system as a survey of ASCs done by Deutsche Bank Securities found that ASCs on average viewed the payment rates under the revised system as a positive. In addition, there is some slight empirical evidence that the revised system has been beneficial. In particular, for the two publicly traded ASC chains, earnings per share increased by 10 percent in 2008 over their 2007 levels. I do caution, though, that the publicly traded ASC chains represent only 6 percent of all ASCs, so this may not be fully representative of the entire ASC industry.

Advocates of the ASC industry have emphasized that ASCs historically have had lower payment rates than in HOPDs. However, the difference in rates between ASCs and HOPDs is getting wider. For example, among all procedures provided in ASCs, the average ASC rate as a percentage of the average HOPD rate was 63 percent in 2008, but this decreased to 59 percent in 2009. However, research by MedPAC and GAO suggests that lower rates in ASCs are appropriate because ASCs have lower costs than HOPDs, and

these lower costs may be driven by, first, less complex patients in ASCs than HOPDs; and, secondly, the fact that ASCs do not face as many regulatory requirements as HOPDs.

Now, it is not clear how much lower ASC payment rates should be relative to -- let me try it again.

It is not clear how much lower ASC payment rates should be relative to the HOPD rates because ASCs do not submit cost data that we need to determine this ratio. We also want to emphasize that although ASCs do have lower payment rates than HOPDs, it is not clear whether providing more care in ASCs necessarily reduces Medicare spending. In particular, most ASCs have some degree of physician ownership, and these physician owners may provide more surgical services in ASCs than they would provide in HOPDs if they provided their surgical care in that setting. Also, ASC capacity has grown rapidly. This expands the overall capacity for outpatient surgery, which may lead to higher overall volume of surgery and, consequently, may increase Medicare spending.

Now, so far we have mentioned that ASCs have not had a positive update to their payment rate since 2003, and that they also face a revised payment system that has

lowered their payment rates for most of the commonly provided services in ASCs; and, finally, that ASC rates are below the rates provided in HOPDs. But an important issue this discussion of payment rates does not address is whether Medicare payments to ASCs are adequate. Indeed, trends in beneficiaries' access to care suggest that payments have been adequate in recent years.

For example, from 2002 through 2007, the number of ASC services per fee-for-service beneficiary has increased by an average rate of 9.8 percent per year, and the number of Medicare beneficiaries served in ASCs has increased by 7.5 percent per year.

In contrast, for HOPDs the number of ASC-covered surgical services per fee-for-service beneficiary has increased by 1.3 percent per year from 2002 through 2007, and the number of all HOPD services per fee-for-service beneficiary has increased by 3.5 percent per year.

In addition, the number of ASCs has increased by an average of 266 facilities per year, which translates to an average annual growth rate of 6.7 percent. Moreover, we estimate that the number of ASCs has continued to grow into 2008 as the number of Medicare-certified ASCs has increased

by 166 from the start of 2008 through the third quarter of 2008.

Now, in addition to the measures of access to care, Medicare spending for ASCs has also increased. We found strong growth in spending per fee-for-service beneficiary, increasing by an average rate of 8.4 percent per year from 2002 through 2007. In addition, CMS projects continued strong spending growth for ASCs, increasing by $1 billion, from $2.9 billion in 2007 to $3.9 billion in 2009.

At this point, I want to mention that factors other than Medicare payment adequacy could have contributed to the increases in access to care and Medicare spending for ASCs. In particular, there have been changes in clinical practice and health care technology that have expanded the provision of surgical procedures into outpatient settings. Also, ASCs may be more convenient than HOPDs to patients, as we mentioned earlier. Also, for all procedures covered under the ASC Payment System, beneficiaries' co-insurance is lower in ASCs than in HOPDs. And then, finally, as mentioned earlier, physicians may find it more convenient to perform more procedures in ASCs than in HOPDs.

Now, an important issue regarding ASCs is that, in

contrast to other health care facilities, ASCs do not submit cost or quality data to CMS, but these data are important for two reasons. First, they would allow us to fully evaluate the adequacy of Medicare payments to ASCs, such as calculating Medicare margins. Secondly, it would allow payments to be based on quality.

So weighing the negative appearance of the ASC payment rates against the positive appearance of measures of payment adequacy, we have developed this draft recommendation: That the Congress should increase payment rates for ASC services in 2010 by 0.6 percent; in addition, ASCs should be required to submit to the Secretary cost data and quality data that will allow for an effective evaluation of the adequacy of ASC payment rates.

In regard to the first half of this recommendation, we arrived at the 0.6 percent because that is the difference between the most recent published estimates of input price increases, which is measured by the CPI-U, as required by law, and the Commission's productivity goal. We also know that the Commission will discuss whether the CPI-U is an appropriate measure of input price increases.

In regard to the second part of the recommendation, in our March 2004 report to the Congress, the Commission recommended that ASCs submit cost data to the Secretary. The purpose of this cost data would be to help determine payment adequacy and would not be used for setting payment rates. In addition, the Secretary has the authority to collect quality data from ASCs and quality measures are available. But CMS has decided to delay the collection of quality data to allow ASCs time to get adjusted to the revised payment system implemented in 2008.

Implications for spending of this recommendation are that ASCs are poised to receive an update in 2010 equal to the full CPI-U. Therefore, this recommendation would reduce program spending relative to current law. We estimate that the reduction would be $50 million to $250 million for one year and less than $1 billion over five years.

For beneficiaries and providers, because of the strong growth in the number of ASCs and the number of beneficiaries treated in ASCs, we anticipate that this recommendation would have no impact on beneficiaries' access to ASC services or providers' willingness or ability to

furnish those services. And we emphasize that maintaining access to ASC services is especially important because beneficiaries typically have lower cost sharing if they receive a procedure in an ASC rather than in an HOPD.

That concludes our presentation.

MR. HACKBARTH: Thank you. Let me just say a word about the recommendation and why I changed this. You will recall at the December meeting the recommendation was for an update equal to the CPI-U minus productivity. The CPI-U is the mandated market basket -- and I use that term in quotes -- for ASCs. Of course, the CPI-U is a Consumer Price Index and not an Input Price Index at all, and Bill Scanlon pointed out that that is a significant, can be a very significant difference in that a Consumer Price Index can be more volatile than an Input Price Index. And the economists can correct me if I am wrong, but a basic reason for that is Input Price Indices, especially when you are talking about health care, have a heavy weighting for wages, and wages tend to be less variable than consumer prices. And we have all seen the variability in consumer prices recently, with particular regard to gasoline prices. The CPI-U is in the process of spiking up and now potentially crashing down,

which makes it undesirable as a basis for payment policy.

So I am recommending we do two things. One is in this recommendation fix the number at the current estimated difference between -- or the current estimated amount for the statutory CPI-U measure minus productivity, and that is 0.6. The second thing I recommend is that, not today but in the future, we take up what would be a more appropriate market basket for the ASC Payment System. I don't think it needs to be a huge issue. There are some candidates that are out there from other provider types, but I just didn't want to do that too hastily and do it on a few minutes' thought. I just wanted to give the staff an opportunity to sort of think through what the best of the alternatives would be. And, you know, potentially, we could come back and vote on that for inclusion in the June report, and so we will have a two-part change in ASCs. So that is the thinking behind the difference between this recommendation and the one you saw in December.

Let me see hands of people who have clarifying comments. Peter and John and Bob and Karen. Peter?

MR. BUTLER: A question on the chapter. On page 64 you have a chart that shows the ownership, whether they

are for-profit, free-standing, urban, and it shows a 99-percent free-standing and 1-percent hospital-owned or -operated.

Now, I think that is misleading, but you can tell me. There are a tremendous number of hospitals that are participating as investors in these outfits. In fact, maybe over half of them have some hospital participation. I don't know the number, but that is part of my question. Because, as portrayed, it looks like these are all free-standing, you know, kind of for-profit operations that are pretty darn independent, when, in fact, hospitals really embrace this as a model themselves.

So do you have any numbers on, you know, what percent have hospital participation?

MR. WINTER: The MGMA asked this in their survey, which is albeit a limited sample size and pretty small response rate. They do classify joint ventures, and it is likely joint venture between physicians and hospitals. I think it is in the 15- to 20-percent range. Do you remember, Dan? We could look it up and get back to you on that.

Regarding the specific number in Table 2, which

comes from the PECOS, the provider enrollment database that CMS has, this information is self-reported by the ASCs and so may not really be very accurate. But I think what they are trying to distinguish between is free-standing could include ASCs that have partial hospital ownership, but they are free-standing in the sense they have their own provider number; and hospital-owned and -operated are more probably fully owned subsidiaries of the hospital. We can investigate this some more. I looked into this several years ago, and I don't recall all the facts. But I can look into this and get back to you on that. And we will certainly get back to you on the MGMA number.

MR. BUTLER: Okay. A second clarification. The average size -- again, because we do not have much data, the average revenue size of the ASC, I am not sure, but I am trying to get some sense of, you know -- I mean, we have one that maybe is an $8 million operation. If you are required to supply the cost information, I am trying to get some estimate of what that might be, probably a couple hundred thousand or something, to put something like that together, depending on what is asked. I don't know. It probably could pretty much chew up the 0.6 percent.

Do you have any sense on what the size of the average ASC is?

MR. WINTER: The MGMA also asked that, so that would be in their survey, and we will look it up and get back to you on that. But I don't know offhand.

DR. MARK MILLER: On the burden of this -- and, Bill, you and I were having some exchange on this, I think, and so if you want to comment. When you think about collecting cost data, you could go wall to wall. You could also think about surveys. And then the size of the instrument here could certainly be contemplated. It doesn't have to be, you know, when you think of the cost reports for the hospitals, the same level of detail there.

DR. SCANLON: The cost is going to depend upon the amount of commingling between the ASC operation and any other operation, because then you are going to have to supply sort of information that wouldn't be in sort of any other financial report. But if you have an ASC that doesn't commingle its books so much with other organizations, you know, we are talking about, we want to know sort of how much is in salaries, how much is in benefits, how much is in sort of rental and other capital expense, and how much is in

supplies -- basic things like that so that we can actually look at margins and look at the weights for sort of a better price index.

MR. BUTLER: I'm in support of the recommendation, but we can get carried away and it becomes an industry in itself if we are not careful about what we are asking for. So none us wants that, and we should have language that, you know, kind of reflects that.

DR. SCANLON: I think setting the goals here, which is to be able to look at margins and to be able to look at sort of appropriate weighting for a price index, there are much more modest goals than trying to say we are going to build a payment system off of this, because what we have done is we have brought in data from the outpatient department as a fundamental building block in the payment system. We are not suggesting that we are going to replicate that, which would be a huge undertaking. I think we make sure what the goals are; then we can keep the requirement limited.

MR. HACKBARTH: I think Peter's suggestion is a good one, that we ought to have a passage in the text that talks about the scaling of this activity, and maybe Peter

and Bill in particular can take a look at that draft language.

MR. BERTKO: A quick clarifying question on slide 8. The first bullet that you have there compares average ASC rates to HOPD rates. Is that a same mix or is it just an average of all kinds of things?

DR. ZABINSKI: It's the same mix. It takes the volume from the ASCs and applies it to the ASC rates, then to the HOPD rates. So it is weighted by the ASC volume.

MR. BERTKO: But is it the same mix of services? Or, you know, do you have five of one and 29 of another? That is my question.

DR. CHERNEW: [off microphone] [inaudible]

DR. REISCHAUER: [off microphone] [inaudible]

DR. MARK MILLER: But not comparable in the sense of -- and, Dan, I want to be careful here, but there is no case-mix adjustment here or anything like that.

DR. REISCHAUER: Just a clarification on slide 9. Am I right in thinking that if I took the line ASC percent increase volume per beneficiary and the bottom line for hospitals' increase of all services per beneficiary and added them together, I would say that the average

participant in Medicare was getting 14 percent more a year of this kind of stuff over a five-year period?

DR. ZABINSKI: My inclination is to say no, because you are working with a different base.

DR. REISCHAUER: Is per beneficiary meaning all Medicare beneficiaries?

DR. ZABINSKI: You might be right, yeah. I'll have to think a little more about that.

DR. REISCHAUER: Why haven't we been jumping up and down about this?

DR. BORMAN: I thought John was going to ask my question, and maybe he did and I just didn't understand the answer. You say in the chapter and I think you mentioned in the presentation that in the ASC there are 20 procedures that account for 74 percent of the service volume. For HOPD, those same 20 services, what percent of the volume do they account for, ballpark? Because the mix of patients part I understand we are not adjusting for. Is there something here about mix of services?

DR. ZABINSKI: Off the cuff, I have no idea what percentage they account for in HOPDs, but I am certain it is much less than 74 percent.

DR. BORMAN: I have no question that the patient populations have some differences. I do not have as obvious an empiricism, and Peter may be able to tell us more sort of what the high-volume things are.

MR. HACKBARTH: Round two questions.

MR. BUTLER: I am comfortable with the recommendation. I do have concerns about the cost of supplying the data because I think most would say, I would rather just forego the increase of 0.6 percent than supply the cost information. That might be one of the conclusions, not worth it. But I can support it.

I would say, as somebody that is involved in both ownership in an ASC and a hospital outpatient department, we very much try to direct patients where they can best be treated and belong. And we very much keep the more complicated ones in the hospital, and it is more expensive. And so I think that, you know, when all is said and done, this is about the right spread, and I am comfortable with it.

The totally free-standing ones, a little different issue, in terms of that perspective. And as I said, I think an awful lot of hospitals are participating in these, and so

I am comfortable with the recommendation.

DR. BORMAN: I'm basically comfortable with the recommendation. I am struck by the savings to the beneficiary, and I think that is hugely important. And I would not want a message to come out of this that we want to discourage the efficient provider of certain services. We have certainly focused a lot of our work and discussion over the last couple of years on identifying and rewarding efficient practice and quality practice. And so I personally regard maybe the cost capture thing as a way to sustain this sector in showing that is an efficient provider. I hope that this is enough to subsidize that cost data reporting, but some mention of this may represent efficient provision and we want to know more about it might be worthwhile.

MR. HACKBARTH: I agree with that, Karen, and Ron and I talked about this as well on the phone. I don't want the message to be, I don't think the message should be that, oh, we see growth, that signifies a problem. I think there are lots of good reasons for significant growth in care in ASCs. Some have to do with changes in technology and anesthesiology and the like. Some have to do with allowing

physicians to be as productive as possible, and I think those are good reasons, and we would make a mistake to retard movement into ASC just because it is growing rapidly.

Having said that, you know, I think it is actually in the industry's interest for us to have cost information. Without cost information, the easy inference that people will make is, oh, it is rapid growth because it is really profitable and we have got to whack 'em. I think there are other reasons for rapid growth. Profitability can be one of them, but I don't think it is the only reason. And having at least some basis for evaluating financial performance allows us to do a more balanced consideration of the volume growth. So I am with you.

DR. SCANLON: You essentially said what I was about to say because I think that is an issue where, when you started to build this payment system, you had a limited amount of information, and I think they did a reasonable job in terms of constructing a payment system. But in thinking about this over the longer term and this being very desirable service, you want to assure that the efficient provider is going to remain sort of in this program. And you can't do that with sort of a lot of confidence unless

you have the information.

There will be days in future years potentially where it is no 0.6, it is something very different because the information was available. And I think that is why it is so critical from both the industry's perspective as well as the program's.

DR. CASTELLANOS: Really the same theme, and to kind of comment on what -- in our community, a lot of times the hospital does not want to provide the technical equipment or the technical staff to do these procedures, so it is a lot easier to do that in an outpatient setting. It is for a cost reason, it is technical support, et cetera.

Karen's report about keeping an efficient system running is really important to the medical community.

MR. HACKBARTH: Any others?

DR. ZABINSKI: A quick answer to Bob's earlier question on this. It would be actually somewhere in between 9.8 and 3.5. It would be a weighted average of whatever the HOPD volume is versus what the ASC volume is. So it would be closer to 3.5 percent than 9.8.

DR. REISCHAUER: You have to label it differently then. What you are implying is that it is only

beneficiaries who go to the ASC, and how --

MR. HACKBARTH: We actually could have done without this clarification.

DR. REISCHAUER: We can battle over this at lunch.

DR. CROSSON: But isn't it a question of whether people go to both or only one? Because if they could go to both, you would have to add them. If they got to only one, it would be the mean.

MR. HACKBARTH: This isn't going to be decisive in my vote.

[Laughter.]

MR. HACKBARTH: So it is time to vote. Would you put the recommendation up?

All opposed to the recommendation? Abstentions? All in favor?

Okay. We are finished. As I explained earlier, we need to have our lunch at 1 o'clock or not at all because of building services, so we have five minutes for a public comment period. The usual ground rules: Please identify yourself and your organization first. In view of the time limits, please limit your comments. If the person in front of you has said the point that you want to make, just say, I

agree with So-and-So. When this red light comes on, I am going to ask you to complete your comment, because we have got to get done.

MS. McILRATH: Without my glasses on, I'm not sure I can see the light, but tell me when I get there.

Sharon McIlrath with the AMA.

I just wanted in the discussion to follow this afternoon, about the size of the pool on the physician payment. I would not that, I believe, in your June report, that you said that you believed that, to provide the 5 or 10 percent bonus to the primary care physicians would cost between 0.5 percent reduction to a 1 percent reduction for other services, and I believe that may be a little understated, because I think that was based on 2006 rather than 2007. So, it didn't include the 10.3 percent increases that Cristina was talking about.

So, if you do that, then you're leaving the other physicians with, potentially, about a freeze in their payments for 2010. So, I just want to point that out when you're thinking about the size of the pool.

The other thing that I wanted to ask was that, in the discussion about sustainability and premiums, that you

do take a more global view. It is not simply physician increases that go into the premiums. They also include the ASCs, they also include the HOPDs, they include some Medicare Advantage, and they include some home health. So, there are a lot of things driving the premium increases, including some benefit increases that were made through a number of the bills that have been passed in recent years, and I believe all of that should be reflected in the discussion.

On the sustainability question, I also think you ought to be looking at the global piece of it. I think Dr. Castellanos mentioned shifts from Part A to Part B. To what extent are the increases in both the HOPD and the ASCs in the physician side helping to keep the Part A inpatient stuff stable and how should you deal with that? Also, when you are changing payments in one sector, for instance -- and I would reiterate what someone said, that the RUC has also said that you need to deal with the volume assumptions on the equipment, but you might want to look at what happens when you do that, and how that's going to then compare to payments in other settings. You might also want to look at what's happening with volume. Is it shifting back to the

other settings when you start reducing the payments on the physician side? How much reduction in volume are you getting versus simply shifting? Basically, my plea is to take an evenhanded approach to sustainability and premiums.

MR. McMANUS: I'm John McManus on behalf of the ASC Association. We welcome the examination that the Commission is given on ASC. It's been about five years since you examined this sector.

I just wanted to underscore a few points that were made as well as illuminate a few others, as well.

Just about five years ago, ASCs were paid -- about 86 percent of HOPD payments for providing the identical services. Because of the six-year freeze and subsequent cuts in the DRA, they are now down to 59 percent, and I think we're getting to the point that services may be unsustainable at that level, and 0.6 percent, while it's better than a freeze, is still pretty low.

I was heartened to hear the Commission recognize that the CPI is not an adequate index; it's really an anachronism from when the ASC payment system went into effect in the 1980s. It was the first PPS system. So, CPI was the only index that was available at the time. We would

suggest, and we hope the Commission can consider, using the market basket of HOPD, since that's a better reflection of ASC costs, because it reflects nurses' wages, medical supplies, things of that nature. So, rather than try to develop a whole new index, just take the market basket and if you're intent on taking productivity out of that, do it off the market basket rather than the CPI.

I think one goal for further study for the Commission ought to be migration. I know this is some concern about physicians producing their own volume, but when you look at the particular services that are high-volume in ASCs, they tend to be nondiscretionary, such as cataract surgery, or preventive in nature and are underutilized, such as colonoscopies. So, I think the larger goal ought to be, how do we get the 60 to 70 percent of services that are now being performed at hospitals for much higher payment rates and much higher copayments -- 50 to 60 percent higher copayments -- at hospitals into the most cost effective, clinically apt place where they can be made.

The last point, on the cost reports, we hope that you recognize that the operational issues of not tying the

cost reports to the payment updates, because it's going to take some time for CMS and ASC to actually be able to produce those cost reports and examine them in a useful way.

A last point: We welcome quality reporting. It was in the statute, we were disappointed that didn't go forward this year, and we think that it should go forward next year without any further delay.

Thank you.

MR. HACKBARTH: We will reconvene at two o'clock

[Whereupon, at 1:00 p.m., the meeting was recessed, to reconvene at 2:00 p.m. this same day.]

AFTERNOON SESSION [2:02 P.M.]

MR. HACKBARTH: The first order of business is to vote on the two physician recommendations, and the only reason I am hesitating is Nancy is not here yet. Mark just went out into the hall to see if he could see her. I told him I'd wait a minute or two before we vote. So, go ahead, talk amongst yourselves for a while.

[Pause.]

MR. HACKBARTH: Okay. We are going to go ahead and proceed with the votes, and if Nancy comes in while we are in the process, we will add her. If not, we will just have to go ahead.

MS. BOCCUTI: What I have up here, we've got two recommendations. The first one is the update one, now with the 1.1 percent. So it is written there on the screen: The Congress should update payments for physician services in 2010 by 1.1 percent.

MR. HACKBARTH: On this recommendation, all opposed to the recommendations, raise your hands? All in favor? Abstentions? Okay, thank you.

MS. BOCCUTI: Then here is the other recommendation. Now this is verbatim from the June 2008

report, and I will read it aloud for the record. The Congress should establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary care-focused practitioners. Primary care-focused practitioners are those whose specialty designation is defined as primary care, and are those whose pattern of claims meets a minimum threshold of furnishing primary care services. The Secretary would use rulemaking to establish criteria for determining a primary care-focused practitioner.

MR. HACKBARTH: What we would do is include some of the language from the June report explaining the rationale for this recommendation.

MS. BOCCUTI: Right. I have also the implications if you want to review them, but they are in the --

MR. HACKBARTH: Why don't you go ahead.

MS. BOCCUTI: The implications for the first recommendation are the same as we did in the presentation this morning. But here for the primary care recommendation, with spending it is a budget-neutral policy, so the fee schedule adjustment would not affect federal benefit spending relative to current law; for beneficiaries, the

adjust could improve access to primary care services; and for providers, for physicians and other providers, the adjustment would have redistributive effects depending on the services they furnish. And this again is verbatim from what was in the chapter in 2008.

DR. REISCHAUER: I just sense we don't know that the first one is true. I mean, we are sort of getting in a time machine.

MS. BOCCUTI: Well, to the extent that CMS will have the adjuster, the modifier, they will determine that amount, and then they will make impact judgments for the future.

DR. REISCHAUER: I'm sorry. I thought this was for the first recommendation.

MS. BOCCUTI: No. The first recommendation, do you want to review the millions -- I mean the billions?

MR. EBELER: Just in particular for the audience, I want to stress that we are repeating this recommendation for emphasis, but as a practical matter, our recommendations are presumed to have standing over time. So the fact that we are not repeating other recommendations that have been made over the last several years doesn't mean that they go

away. So this is an emphasis point, not a downplaying of other recommendations.

MR. HACKBARTH: Good point. Okay, ready to vote on recommendation two. Do you want to put it up there, Cristina?

MS. BOCCUTI: Do you mean the update one or the --

MR. HACKBARTH: The second one, on the primary care.

MS. BOCCUTI: Right. We did the first one.

MR. HACKBARTH: So on the recommendation for primary care modifier, all those opposed to the recommendation? All those in favor? Abstentions? Okay. Thank you.

So we are now ready to move ahead with dialysis services.

MS. RAY: Good afternoon. During today's presentation I'm going to first highlight some information that we did not focus on during last month's presentation, and then I'm going to summarize key information about the adequacy of Medicare's payments for dialysis services.

Lastly, I will present a draft recommendation for you to consider about updating the composite rate for

calendar year 2010. This will be our last presentation before the March report.

So, access to care for most beneficiaries appears to be good. I want to highlight just two new pieces of information.

First, there's little change in the mix of patients that providers treat. For example, the demographic and clinical characteristics of patients treated by freestanding facilities that account for about 85 percent of all facilities did not change between 2006 and 2007.

Second, with respect to facilities that closed, some of what we found is intuitive. Facilities that closed are more likely to be smaller and less profitable than those that remained in business. This year we do not the differences in patient characteristics in the facilities that closed compared with those that were in business in 2006 and 2007.

So, last month, there were a couple of questions about this map. First, we have fixed a software glitch that left off a few facilities, particularly in Oregon.

[Laughter.]

MS. RAY: They are back. The map that you see

here is complete.

Last month, there was also a discussion about beneficiaries' access to care in rural areas. I wanted to point out a couple of points about this.

First, about one-quarter of all dialysis facilities are located in rural areas. This is consistent with the characteristics of all Medicare patients. In 200f, close to one-quarter of all benes resided in rural areas. I was able to find one study that estimated that 22 percent of new dialysis patients lived in rural areas, so, again, that's consistent with the quarter of all facilities located in rural areas.

Second, growth of dialysis facilities in rural areas is comparable to the growth of facilities in urban areas, both on a five-year and for 10-year periods.

Third, the published literature on the characteristics of rural dialysis patients is scarce. One study reports that although hemodialysis was the dominant modality in both urban and rural areas, use of peritoneal dialysis was more frequent in rural areas. So, for next year, we intend to take a closer look at access to care issues among rural dialysis patients, and this will require

analyzing claims at the beneficiary level.

So, just to summarize the points of this slide, the proportion of facilities in rural areas is consistent with where Medicare patients live, growth in rural and urban facilities is comparable, and we plan to do more work on this issue next year.

Moving onto changes in the volume of services. I just want to point out one item here. We do find this year a small decrease in the per treatment use of epo between 2004 in 2007. The changes in epo use are related to changes in law and regulation and how Medicare pays for dialysis drugs. In addition, there have been recent studies that were published in peer review that showed the risks of too much of erythropoietin.

Reviewing information about dialysis quality. As you recall, last month, we reviewed several measures on dialysis quality. Carol and Ron had several questions about kidney transplantation. As a result, we have included as a quality measure, the proportion of all dialysis patients that are registered on the kidney transplant list. This is an aggregate measure for all dialysis patients.

In addition, the revised chapter includes a text

box that begins to address some of the issues that you raised, and we do intend to continue to work on this issue.

So, now, Hannah is going to summarize the discussion that we have included in the paper.

MS. NEPRASH: Experts agree that kidney transplantation is the best treatment option for individuals with ESRD. It reduces mortality and improves the quality of life.

The number of kidney transplantations in the United States has steadily increased, surpassing 18,000 in 2006, the most recent year of available data. Demand for kidney transplants seems to outpace supply. While the number of transplantations increased by 4 percent from 2005 to 2006, the number of patients on the waiting list grew by 8 percent in the same time period.

Like dialysis, Medicare covers the cost of kidney transplantation for any ESRD patient who is eligible for Social Security benefits. The original 1972 law extended full Medicare benefits to kidney transplantation patients for one year. Current law mandates that all individuals receiving a Medicare-covered transplant are eligible for full Medicare benefits, including the immunosuppressant drug

benefit for 36 months following a transplant.

Now, some demographic analysis of the kidney transplant wait-list population. Access to kidney transplants varies by factors including race, insurance status, geographic location, and dialysis facility ownership. Africa Americans have higher rates of ESRD than Whites, yet they are underrepresented in the transplant population. On average, African Americans on the transplant wait list have spent more time on dialysis than White patients, a factor that decreases the probability of a successful transplant. They're also likely to wait longer for a transplant than their White counterparts.

Access also varies by insurance status. Research shows that Medicaid ESRD patients are less likely to be placed on the waiting list that their dual- eligible or Medicare-only counterparts. Similarly, the uninsured are unlikely to receive a transplant, yet they represent roughly 18 percent of kidney donors in a recent study.

Residence in a rural area also decreases the likelihood of obtaining a new kidney; however, rural patients who are wait-listed do not wait longer or have significantly different clinical outcomes than their urban

counterparts.

Finally, the ownership of a dialysis facility may affect a patient's likelihood of placement on the transplant waiting list. While the study is almost 10 years old, researchers found that for-profit ownership of dialysis facilities, compared with not-for-profit ownership, was correlated with decreased rates of placement on the kidney waiting list.

With that, I'll turn it over to Nancy.

MS. RAY: Okay. Here is the Medicare margin for both composite rate services for both composite rate services and dialysis drugs. It was 4.8 percent in 2007, and we project it will be 1.2 percent in 2009.

You may question why the 2009 projection is much lower than 2007 actual margin. The principal factor is that the growth in the market basket is higher than the update to the composite rate. The composite rate was increased by 1.6 percent in 2007 and 1 percent in 2009. There was no update to the composite rate in 2008.

You can see here that the Medicare margins varies across the different provider types. It was larger for the two largest chains than for other freestanding facilities.

There are three reasons for this result.

First, the composite rate cost per treatment is lower for the two largest chains than for other freestanding facilities.

Two, dialysis drugs are more profitable for the two largest chains than the other freestanding facilities.

And lastly, drugs account for a larger share of payment for the two largest chains than other freestanding facilities.

Before moving to our draft recommendation, let me summarize our findings: Most of our indicators of payment adequacy are positive. Our analysis of beneficiary access is generally good. Providers' capacity is increasing as evidenced by growth in dialysis stations. Volume of services of dialysis treatments is increasing. Quality is improving for some measures and providers appear to have sufficient access to capital as evidenced by the growth in the number of facilities and access to private capital for both large and small chains.

This evidence suggests a moderate update of the composite rate is in order, and the dialysis providers can achieve efficiency gains similar to the economy at large,

which is 1.3 percent for our 2010 deliberations.

In December, you began your discussion with last year's recommendation of the dialysis market basket minus productivity. However, current law is for an update of 1 percent in calendar year 2010 and the Chairman is starting today's discussion with the draft recommendation that the Congress maintain current law and update the composite rate by 1 percent for calendar year 2010. This draft recommendation closely approximates an update based on the current forecast of the ESRD market basket of 2.5 percent, less the Commission's adjustment for productivity growth. You will note that this draft recommendation does not reiterate the Commission's recommendation on implementing a payment incentive program, because MIPPA mandates that, beginning in 2012, the Secretary link Medicare's payment under a broader bundled payment system to the quality dialysis providers furnish.

So, here are the implications of the draft recommendation. On spending, this recommendation would not increase spending relative to current law. For beneficiaries and providers, it does not increase beneficiary cost sharing relative to current law and we do

not think that it will impact providers' willingness or ability to serve beneficiaries.

MR. HACKBARTH: Thank you, Nancy.

Let me just elaborate on what Nancy said about the reason for making the recommendation of 1 percent as opposed to market basket minus productivity. As Nancy said, market basket minus productivity, based on current projections, would be 1.2 percent.

For dialysis providers, as well as all other providers, there is not a single right answer as to the update, as everybody well knows. There are, in fact, a range of reasonable update numbers. We ultimately have to agree on one and I thought the 1 percent was well within the range of reasonableness, around 1.2. I thought it was appropriate to use the 1 percent in this case because it is what is provided for in current law, not just for 2010 but also 2011, as I recall. There were two years of 1 percent update. Feel free to correct me if I'm wrong on that, Nancy.

But there were also some other provisions in the legislation where this 1 percent update for 2010 was established. Briefly put, they involve moving towards a

bundled payment system. And then, after the bundled payment system is in effect, having a baseline increase for dialysis services.

I don't want to get too much into -- go ahead Nancy.

MS. RAY: The 1 percent was for 2009 and 2010.

MR. HACKBARTH: 2009 and 2010. Thanks for the correction. And 2010, of course, is the year that we're voting on now.

So, the other piece of this package on dialysis payment was, in addition to going to a bundled payment, it provided for a baseline increase in dialysis services, something that dialysis providers have long sought.

Briefly put, the significance of that is, once you've got a baseline increase on your rates, you can get that amount without any incremental budget cost, whereas if you have no baseline increase, any increase at all in the rates has a budget cost attached to it and that much more difficulty associated in winning the update during a Medicare bill writing.

So the industry wanted to be like other provider groups and get this baseline increase in the future. I

think that begins in 2012, is that right, Nancy? I think it starts in 2012.

MS. RAY: I will double-check that, but yes.

MR. HACKBARTH: So, long story short there were multiple provisions and a bill reforming dialysis payment, one of which was the 1 percent. And it seemed to me that, rather than undercutting that agreement that had been worked out in the Congress with the dialysis industry, since it's certainly within the range of reasonableness, the appropriate thing for us to do was to go ahead and recommend the 1 percent. So that's how I got to where I am.

Nancy.

MS. RAY: The statutory update kicks in in 2011, which would be market basket minus one.

MR. HACKBARTH: Okay. So, I had my years out of sequence. It was 2009 and 2010 that was 1 percent, and 2011 and beyond it's the baseline increase. Okay. So, that's how we came to this recommendation.

Any questions about that or clarifications needed?

MR. BUTLER: Just a tad uneasiness in the sense that if we were truly 100 percent independent, are you saying that your recommendation as Chair would be one 1.2?

MR. HACKBARTH: No, I'm saying we are independent and my recommendation as Chairs is 1 percent.

MR. BUTLER: But it's taking into account your knowledge of where Congress is at.

MR. HACKBARTH: Yes.

MR. BUTLER: So, in the sense of -- if they had no provision -- state it differently: If there was nothing in the law that spoke to this, in the absence of that information...

MR. HACKBARTH: Maybe I've been doing this too long, but my definition of the real world actually includes the Congress.

MR. BUTLER: Well, we're the customer -- I mean, they're our customer, so to speak.

MR. HACKBARTH: Yes.

MR. BUTLER: Yes.

MR. HACKBARTH: I think this is a reasonable and appropriate number, taking all factors into account, is my answer.

Anybody else want similar illumination? Hearing none, let's proceed to vote.

All of those opposed to the recommendation? All

in favor? Abstentions?

Okay. Thank you very much.

MR. HACKBARTH: Next is skilled nursing facilities.

DR. KANE: [off microphone] [inaudible.]

MR. HACKBARTH: I didn't mean to do that. I guess I just sort of...

DR. KANE: [off microphone] I only asked for clarifying questions in the recommendation, and I think we are -- I didn't realize you meant the whole [inaudible].

MR. HACKBARTH: First of all, it was unintentional. I guess I just stroked out here for a second. Well, let me think for a second what to do about that. Maybe the direct thing to do is, based on his novo, George may have something that he wants to say by way of explanation. Let me do that as an immediate step.

MR. GEORGE MILLER: Yes, I'll be happy to. I said it in executive session, but I'll be glad to say it here, again. I am very troubled, and I really appreciate the staff for uncovering the rock of the issue of the disparity for Afro-Americans in getting placed on the transplant list. That's very troubling to me and I think that both Mitra and

Jennie mentioned about the impact on beneficiaries. And this is, in my mind, a major issue on impact on beneficiaries where Afro-Americans and other minorities are 3.5 times more likely to have end stage renal disease, but yet to not get placed on the facility.

I didn't get to ask the question, but I believe there was a correlation between for-profit entities and the number who also get served and get put on that list. That troubles me greatly, and I do not think that they should get an increase. I think Susan said earlier another issue about political will. This is one where it is an ethical and moral issue for me, maybe for no one else, but for me. So I cannot support an increase for those reasons.

MR. HACKBARTH: And I apologize, George. I didn't mean to deny you an opportunity to address that.

As I said in our earlier discussion on this, I share your concern about that and I think it's an important problem and one that we ought to figure out how to address, whether there are policy tools that we can apply to address the problem.

Thank you, Nancy, for waking me up.

Anything else people want to say specifically

dialysis?

DR. DEAN: Is there a way in the chapter that we could allude to George's concern and highlight a bit, that this is an area that the Commission is concerned about?

MR. HACKBARTH: Yes.

DR. DEAN: And that we don't have a policy recommendation to address it directly but that we really would expect to see this dealt with one way or another?

MR. HACKBARTH: Absolutely. Yes.

MS. HANSEN: Yes. I had a chance to talk with George separately. Just, in general, that I think this one example probably highlights some earlier discussions we have had in the Commission about when health disparities come up, and perhaps that could be a larger approach to it. This is something that is very vividly strong, but it does show up in different variations. In some places, no, but more often than not, yes.

MR. HACKBARTH: Yes, it does.

As I've mentioned this morning, when I testified on the March report last year before the Ways and Means Committee, Congresswoman Tubb Jones from Cleveland really made a point of this and they gave me a very hard time about

what she considered to be a failure of MedPAC to give due attention to disparities.

After it was over, I said to Mark I thought she had a reasonable point. I'm not sure exactly how we can best address that, but I do think it's a problem that we need to try to figure out how to more systematically address in the future.

DR. BORMAN: Just briefly, first, I appreciate that some of my comments were so taken to heart by staff, and taken so much further in a better way than I could ever have done. I would like to point out couple of things, however.

One, I think maybe the quality measure, and I think this is a harder number to get at, is not necessarily the percentage who get on the wait-list, which I think is a good measure to know and these are important and valuable data, and I'm going to come back to them in a minute. But perhaps the more defensible or more understandable quality measure might be, are people being appropriately referred for evaluation as transplantation candidates? Because we have to be a little bit careful about whether or not people then, once evaluated, truly are candidates, and that may not

be equivalently distributed across a variety of demographics in terms of gender, in terms of age, in terms of a whole bunch of things.

So, just to be clear, I think this is great work, but we might want to say that we're not sure what the best measure related to quality and transplantation is. Here are the data that were readily accessible and they do open some questions.

Relative to that, I would say that some of this -- and this goes back to, is there a multiple regression, if you will, effect here that, in transplant candidacy evaluation, a number of things are taken into account because it's hugely important in terms of your psychosocial support system post transplant, your personal motivation about adherence to what can be very complex and very difficult drug regimens, the time that you take a given immunosuppressive variation by 30 minutes or what you ate at your last meal can be hugely important. And so, the ability to get a patient who can participate in getting the most out of scarce organs is very important. That's not to say that we don't need to do our best to make sure that that's a fair process, but do understand that there is a lot that goes

into that decision about, are they a candidate or not, and maybe the more generic measure is, were they considered as a candidate. So, I would just clarify that one piece.

MR. HACKBARTH: Any others? Again, I apologize for cutting off the discussion.

Carol.

DR. CARTER: Last month we considered information we used to assess the adequacy of Medicare payments using our standard update framework. I will briefly review that information and the draft recommendation. Several of you, Mike, Mitra and Jack, mentioned the need to link the recommendation to other previously made recommendations that affect the distribution of payments, and I'll talk about that at the end.

The indicators we examined suggest that payments are more than adequate. Supply has been fairly stable for several years.

Bruce, you asked about the entry and exit into the market, and the revised draft provides more information on that.

There were about a hundred new SNFs this past year, and about as many closed.

I also added some discussion about state policies that affect this sector's ability to expand. There was a slight increase in the volume of services on a fee-for-service enrollee basis. Access remains good for most beneficiaries, because Medicare continues to be considered a good payer. Access can be delayed for beneficiaries with medically complex care needs.

Jennie, you asked to see a little more description about the types of patients who experienced delays and I added several examples into the chapter.

The quality indicators show mixed performance. Risk-adjusted rates of community discharge show improvement, while rates of rehospitalization continue to deteriorate. Access to capital is expected to be tight over the coming year, but this is related to the state of the financial markets, not the adequacy of Medicare payments. Medicare continues to be preferred payer.

Last month, I also described three tends and services used that underlined the problems with the current PPS design. You have already made recommendations addressing each one.

First, we see a growing concentration of special

care in clinically complex admissions and fewer SNFs. This concentration reflects the poor targeting of payments for non-therapy ancillary services, and the fact that therapy payments are not proportional to therapy costs, making rehabilitation cases relatively more attractive.

Second, we also see continued growth in the number and intensity of rehabilitation days, reflecting the incentive to furnish therapy and the mismatch between therapy payments and therapy costs. Last summer, you recommended adding a separate component to the PPS to pay for non-therapy ancillary services and replacing the current therapy component with one that bases payments on predicted care needs, not the amount of service furnished.

Mike, you asked about the impact of these proposed changes and I added to the chapter a discussion of the shifts in payments that would result.

The third trend is the growing share of days qualifying for rehabilitation plus extensive service case-mix groups, which have the highest payments. Because this trend is likely to reflect services that were actually provided during the prior hospital stay, you recommended gathering the information necessary to distinguish between

services furnished by the SNF from those provided by the hospital.

Turning to our analysis of margins, the aggregate Medicare margins for freestanding SNFs was over 14 percent in 2007. This was the seventh year in a row that freestanding facilities had aggregate margins exceeding 10 percent. There continues to be wide variation in the financial performance, as you can see from the differences in margins for SNFs at the top and bottom quartiles, and the differences between nonprofit and for-profit SNFs. Hospital-based facilities continue to have large negative margins.

Karen, you asked about the total facility margins and I've included those in the chapter. In 2070, the aggregate total facility margin was 2.4 percent. At the last meeting, we discussed the reasons why using Medicare payments to cross subsidize Medicaid payments is inadvisable.

We estimate that the Medicare margin for freestanding SNFs in 2009 will be 12.6 percent. We think our projected margin is conservative because we used the actual average annual cost increases over the past five

years, which is higher than the forecasted market basket increase, and we did not factor in any behavioral offset that might increase payments.

This leads us to the Chairman's draft recommendation. The Congress should eliminate the update to payment rates for skilled nursing facilities services for 2010.

Our rationale is consistent with the recommendations from previous years: Margins continue to exceed 10 percent and are more than adequate to accommodate the expected cost growth. This recommendation would lower program spending relative to current law by $250 million to $750 million for Fiscal Year 2010 and by $5 billion to $10 billion over five years. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

At the last meeting, the Commission discussed the need to consider the update recommendation in tandem with previously made recommendations. While the update recommendation addresses the level of payments and aggregate spending, other recommendations are key to redistricting payments. Revisions to the PPS would shift payments away

from therapy cases and towards medically complex stays and patients with high non-therapy ancillary costs. The adoption of a pay for performance program would decrease payment to poor-quality facilities and increase them for high-quality providers.

The text in the chapter discusses the need to adopt all three recommendations to control spending increases and to redistribute payments so that they're more equitable across types of cases and the SNFs that treat them. The Commission's previous recommendations are now going to be in a text box.

And with that, I can answer any questions and look forward to your discussion.

MR. HACKBARTH: Clarifying questions for Carol?

MR. BUTLER: I'm just curious. You mentioned the total margin that Karen requested is two point-what percent?

DR. CARTER: Four.

MR. BUTLER: Is there anything to be learned in this sector similar to what we presented in the hospital sector? And that is, the ones that are more financially stressed, do they have a higher Medicare margin in SNF Medicare similar to what's going on in the hospitals? It's

very different in the sense that Medicare, here, is profitable, but nevertheless you would think there might be some similarities, do we know anything about that?

DR. CARTER: I haven't looked into that. I would remind you that Medicare is a very small piece of the action here, which is a little different than in hospitals. So, we may see less of the kind of relationship that you're looking for, but I haven't looked at that.

MR. HACKBARTH: Other clarifying questions? How about round two questions? How about a vote? Are you ready to vote?

Okay. On the recommendation, all opposed to the recommendation? All in favor of the recommendation? Abstentions?

Okay, thank you very much.

Next is home health.

MR. CHRISTMAN: Next, we are going to do home health, and today our review is going to have three parts: first, I am going to review the payment adequacy indicators for 2009; second, we are going to review the factors driving the high payments Medicare makes for home health; and, finally, we are going to turn our attention to the

recommendations.

First up is access and supply, and as in previous years, the supply of providers and access to home health is pretty good: 99 percent of beneficiaries live in an area served by one home health agency; 97 percent live in an area served by two or more. The number of agencies was over 9,700 by the end of 2008, about a 4 percent increase over 2007. Since 2003, the number of agencies has increased by about a third, or an additional 2,400 agencies.

For 2007, the trends in the types of agencies entering are unchanged from previous years. Most are for-profit and most are concentrated in a few states. Concern about concentration has led CMS to launch efforts to curb fraud and abuse. CMS began efforts in 2007 in L.A. and Houston and recently expanded those efforts to Miami-Dade County in Florida.

Use of the home health benefit has increased significantly in the last five years. The number of users has increased to 3.1 million in 2007, which equals about 9 percent of fee-for-service beneficiaries. The number of episodes has risen 41 percent since 2002 to 5.8 million in 2007. The episodes per user have also risen, implying that

beneficiaries are staying on home health service for longer periods. Episodes per fee-for-service beneficiary have risen by 41 percent since 2002, indicating that the growth in the benefit has been much greater than the growth in enrollees.

The mix of episodes is also shifting towards higher-paying services. The share of episodes with ten or more therapy visits which qualify for bonuses of $2,300 or more has increased from 23 to 28 percent.

Overall, home health agencies appear to have adequate access to capital despite the current credit issues. It is worth noting that home health agencies, even publicly traded ones, are less capital intensive than other health care providers. They require relatively little capital as they do not have to build the physical plant that other providers require. That said, agencies meet their capital needs in a variety of ways.

Many agencies, typically the smaller or mid-sized, are able to borrow against their receivables, such as their projects Medicare payments, to meet their credit needs. The large for-profit, publicly traded companies access capital through the credit markets, but so far the tightening of the

credit market has not affected them significantly.

Going forward, the industry anticipates a challenging credit market, but they do not believe that any of their business operations or strategies need to change as a result. The major for-profit chains have aggressive expansion plans for this year, and the recent trouble in the capital markets has not caused them to reconsider their plans.

For the industry as a whole, the entry of new providers suggests that agencies are finding the means to expand. Though we have seen entries slow in recent years, this is likely due to a change in the accreditation process. Many state survey agencies have reduced or stopped efforts to certify new agencies, and consequently, most new agencies have to go to private accreditation services instead. The result is that while fewer new agencies are being certified, those agencies that are coming in are willing to pay for certification when their predecessors frequently did not. This suggests that interest in entering the Medicare home health market remains strong, even though there has been some slowdown in the rate of entry.

This next table shows risk-adjusted quality

measures for home health, and with a few notable exceptions, the table shows that they have gradually improved.

For the first five measures, all measures of a beneficiary's functioning, such as the ability to get out of bed or bathe, the steadily rising line indicates that there has been a consistent increase in the number of beneficiaries who improved on these measures.

The bottom blue line is the rate of hospitalization. A decline would indicate improvement for this measure. However, the rate of hospitalizations has not changed in most years, though there was a one-percentage-point increase in 2008.

Next, we turn our attention to margins for 2007. You can see that overall margins for 2007 are 16.6 percent, but there is a significant variation within that. For example, the agency at the 25th percentile in the margin distribution had a margin of 3.1 percent while the agency at the 75th percentile had a margin of 26.3 percent.

The patterns for margin by geography and type of control are similar to what we have seen in previous years. Margins for providers that serve both urban and rural areas, referred to as mixed here, had the highest margins. Rural

areas had the lowest margins, but those margins were still 14 percent. For-profit margins equaled 18.6 percent, and the not-for-profits were 11.9 percent. And I would note that in our margin projections that I am about to walk you through for 2009, we only project margins for free-standing providers. Hospital-based providers whose margins were included in those reported during the review of hospital payments earlier today averaged a margin of negative 4.5 percent in 2007.

Next, we will discuss the changes to payments and costs for projecting margins for 2009.

There are two policy changes for 2009 that we need to include in our modeling. The first of these is a payment adjustment for changes in coding practice since PPS was implemented in 2000. This policy will decrease payment. CMS found that almost all of the change in case-mix between 2000 and 2005 was for reasons related to changes in coding practice, not changes in patient severity. As a result, they are lowering payments in 2008 through 2011 to bring payments down. The reductions for 2008 and 2009 have been implemented, and additional reductions totaling about 5.5 percent are planned for 2010 and 2011.

Then there is a second change. CMS implemented PPS refinements in 2008 that will result in future coding changes which will increase payment. We assume that future changes in coding practice will raise payment by 1.6 percent in 2008 and 2009.

With these assumptions for 2009 policies, we turn our attention to the margins. The base rate will increase in 2009 by about a tenth of 1 percent, and, again, this is the impact of two policies: a 2.9-percent increase in the market basket and a 2.75-percent reduction for changes in coding practice. Because the increase in the market basket is slightly larger than the coding reduction, the payment increase for 2009 is slightly positive. And in terms of cost per episode or cost growth, we found that costs grew by less than 1 percent in 2007, and this is consistent. We found that average cost growth has been about 1.5 percent a year since 2001. However, cost growth has been erratic in recent years, with growth being about 1 percent in 2005, 3.6 percent in 2006, and, again, less than 1 percent in 2007. So to be conservative, we assume market basket of 2.9 percent. And as you can see at the bottom of the slide, we estimate margins of 12.2 percent with these assumptions.

So reviewing our payment adequacy indicators, it is very similar to what we found in past years. Beneficiaries have widespread access to care, the number of agencies continues to rise, and we also see growth in episodes and the rate of use. Quality show improvements on most measures, and the margins are, again, 12.2 percent.

In the past, the Commission has recommended no market basket update when reviewing these indicators. However, the consistently high margins of home health providers raise questions about the adequacy of this approach. Since 2002, home health margins have averaged 16.5 percent. These margins have remained high despite numerous adjustments to the market basket. In 2002 through 2005, the market basket update was reduced on average by about a point each year. And in 2006, it was eliminated entirely.

The high margins are the result of at least two factors. The first is that home health agency cost growth has been lower than the payment updates in most years. The average growth in cost per episode has been about 1.4 percent a year, while the rate of inflation assumed in our payment updates have averaged about 3.3 percent a year

before any reductions. Because actual inflation has been lower than market basket inflation, payment increases have exceeded the growth in providers' costs in most years.

In addition to low-cost growth, another reason for the high payments are that Medicare's base rates are based on obsolete assumptions about utilization. The rates assume a much higher average level of service than is actually provided.

When setting the initial rates for the PPS, CMS relied upon data about the number of visits that occurred in 1998 when the IPS was in effect, which equaled 31.6 visits. However, the average number of visits dropped between 1998 and the implementation of PPS to about 21.8 visits, which is about equal to the 22 visits provided on average in 2007.

The difference between the visit level included in the base rate and the level actually provided under PPS means that the actual cost for an episode is significantly lower than what was assumed when the base rate was set. Because providers delivered fewer visits than assumed, the payments under PPS have been consistently greater than provider costs.

The assumption of more visits results in a much

higher base rate. If we were to reset rates with 2007 data, the base rate would be about 20 percent lower. The significant drop in visits may raise concerns about stinting, but the changes had little or no detrimental impact on quality. MedPAC and others found that the quality provided under PPS was equal to the care provided during the period immediately preceding it.

The Commission's goal for Medicare is that they be adequate to cover the costs of efficient providers. As long as our payments rely on outdated assumptions about utilization, it seems home health payments will be far from this goal.

These facts suggest that there is a need for fundamental change in the home health payment factors. The rates Medicare uses today are obsolete because they reflect utilization from a period prior to the incentives of PPS. They result in payments that are far in excess of cost. These overpayments do not accrue to the benefit of either the beneficiary or the program. These overpayments contribute to the drain on the Hospital Insurance Trust Fund, which will be bankrupt in 2019, less than ten years from the year we are providing payment recommendations for.

Also, since a portion of home health is covered by Part B, these overpayments contribute to the growth in beneficiary premiums and increase the amount of money Medicare must take from the general fund. These rates are likely to remain high if we rely on the market basket along to adjust payments. This has been the experience in the past seven years and suggests that more aggressive changes are necessary. Given the changes that have occurred in utilization since the base rate was establish, an ideal approach would be to rebase home health payments to reflect the actual cost of care under PPS.

This brings me to the draft recommendation for 2010. Because rebasing the actual cost would significantly change payments, our draft recommendations do this is an approach that spreads the change over two years.

The first recommendation would eliminate the market basket update for 2010 and advance a reduction CMS has planned for 2011 to occur one year earlier, in 2010. The net effect of these two actions is that 2010 payment rates will be 5.5 percent below 2009 levels. Note that this recommendation would cut payments but not set them equal to costs. This would reduce spending -- excuse me. Let me

read the recommendation.

The Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments in 2011 to 2010 so that payments in 2010 are reduced by 5.5 percent from 2009 levels. This would reduce spending by $1 to $5 billion in 2010 and $5 to $10 billion over the five-year period. And we expect that the beneficiary and provider implications are that this would have no impact on providers' willingness or ability to serve Medicare beneficiaries.

The second recommendation would complete the rebasing. Under this recommendation, the home health base rate would be reset to equal cost in 2011, and this would end the use of the obsolete factors in use today. It reads: The Congress should direct the Secretary to rebase rates for home health care services in 2011 to reflect the average cost of providing care.

This recommendation is expected to result in a decrease in spending, but it is difficult to estimate the amount because a precise reduction would depend on the Secretary's analysis of the cost of an episode in 2011.

Now, we expect that a change of this magnitude

would result in some agencies leaving the program. However, we expect beneficiary access to be adequate even with the reduced agency supply. To understand why, let me review with you how access to care and supply of agencies has changed in the last five years.

In 2003, we reported that 99 percent of beneficiaries lived in an area served by home health, and in that year there were about 7,300 agencies. Since that year, the number of agencies has increased by over 2,400, but the number of beneficiaries in an area served by home health obviously has not changed.

Given that almost all beneficiaries had access to home health five years ago when there were 25 percent more agencies than we have today, we would expect that access to care would remain adequate, even if supply contracts in the future, because of our recommendation.

Lower rates could raise concerns that providers would reduce services to lower their costs. To address these concerns, the Commission could recommend that the Secretary pursue policies to safeguard care. It reads: The Congress should direct the Secretary to assess payment measures that protect the quality of care and insurance

incentives for the efficient delivery of home health care. The study should include alternative payment strategies, such as blended payment and risk corridors and outcome-based quality incentives, and we expect that this would have little cost, small administrative cost, and, again, because we are not changing provider payments, we wouldn't expect it to have an impact on provider willingness or ability to serve Medicare beneficiaries.

That completes my presentation.

MR. HACKBARTH: Thank you, Evan.

Clarifying questions for Evan?

MS. BEHROOZI: Thanks, Evan. What share of the industry revenue is from Medicare; do you know?

MR. CHRISTMAN: I believe it is somewhere around 30 or 40 percent.

MR. GEORGE MILLER: Is there any reason in the recommendations that we could not change recommendation draft two to read, to rebase the rates for home care to 2010? Is there any technical reason we couldn't do that, from 2001?

DR. MARK MILLER: Actually, if I could say something about this, the way the recommendation reads is it

says to rebase it in 2011 to reflect average costs of providing care, and in the way you talked about it, it sounded like we were saying care in 2011. It is not possible, really, for the agency to be looking at, you know, the data from 2011 and rebasing in a year concurrently, I don't think. So there will be some -- what I think we are saying here is rebase it in 2011 using the latest data that you have, is what I think we are really thinking here.

MR. GEORGE MILLER: My question is a little different. Could we advance that one year earlier and ask for the rebasing to be done --

DR. MARK MILLER: [off microphone] I misunderstood.

MR. GEORGE MILLER: Is there a technical reason why we could not rebase, set the rate in 2010 instead of 2011?

MR. CHRISTMAN: I think there are probably some technical reasons it would at least be challenging to do it in 2010. One is that they are probably not going to want to do this unless they have audited cost reports. There aren't any. They will have to do that. That is one thing that would eat up time. And I guess I would offer that it would

probably be reasonable to use cost reports that reflect costs under the refinements that were implemented in 2008, and those 2008 cost reports won't be available until this fall.

DR. KANE: In the written material on page 21, you mention that the Deficit Reduction Act eliminated the update for 2006 and, despite that reduction, average payments perhaps increased by 4.5 percent. Was that because they all moved into higher-level therapy visits? Or do we know why that was? Or is that something we also have to guard against when we continue to do a zero update?

MR. CHRISTMAN: You flag it exactly. Therapy was probably a part of that, but it would just be a larger move in terms of just higher case-mix. And therapy is one thing that drives up case-mix in this case. But there are a couple of other things that drive it up as well.

You know, we have seen an increase in the number of outlier payments, and we have seen an increase in the number of full episode payments. If your episode has fewer than five visits, you get paid on this modified per-visit payment system that is at most a couple hundred dollars in most cases. The average full episode payment is $2,700, so

what we are seeing is fewer cases. Fifteen percent or so of those episodes used to be paid on the per-visit system, and now it has fallen to 10 percent. And the converse, as the number of full episodes has increased, the average payment has gone up.

DR. KANE: I guess the other question, this system seems awfully vulnerable to people just doing minor -- I don't use the word -- I don't like to use the word gaming, but I guess it is. Is there any safeguards against the gaming that could be put in that would make -- if you say a zero update, you know, doesn't it just have them do something like that? Because, otherwise, it is kind of a meaningless update recommendation.

MR. CHRISTMAN: I guess the points I would make, I'd just address maybe the first part of it. You know, in all of these things, there is a hope that medical review will catch some of the people who are pushing limits. In terms of the -- part of the challenge with home health is it is a very heterogeneous population that has a big variation in the types of services that they need. And so the best answer that I think we have to it so far is that, you know, there has to be hopefully some flexibilities in there. Of

course, it does lead to the vulnerabilities you are pointing out.

DR. MARK MILLER: I guess I would also just draw your attention to there are three parts to the recommendation. There is the zero update; then to start the rebasing process, which is kind of the first and the second, but the second recommendation; and then the third recommendation, and we would be doing this in the background as well, too, is to look at some of these other ways to approach the payment system where you could begin to put some of the brakes on some of the behavioral stuff.

Could you have an aggressive quality-based measurement system that would work against stinting? Bill has brought up issues that -- I don't have quite the language right, but the corridor type of thing, you know, how much either change in cost or change in profitability and sort of looking at things like that.

And I think what the third recommendation is we need to think about that. We are asking the Secretary to do it. We also plan to be doing some of that.

MR. HACKBARTH: As Bill has said and people say -- and, again, in 30 seconds -- a core problem here is a weak

product definition of what exactly we are buying.

Bill, what do you think about that?

DR. SCANLON: I thought I couldn't comment because this was round one. I was going to ask a question.

MR. HACKBARTH: That is right, so we will cut you off.

DR. SCANLON: But you can put me down for round two as well. My question, though, was on the quality measures. Are they case-mix adjusted? Since you said that there has been a shift in case-mix.

MR. CHRISTMAN: Yes.

DR. CROSSON: This is a clarification that borders on substance, but I will try not to -- and it has to do with the rationale for recommendation one. It sounds like from the presentation, at least the one that was emphasized, that one of the reasons for the higher margins is less visits, substantially less visits. And, admittedly, there is a coding issue going on also. But the one we were focused on was less visits.

So I am sort of wondering why we are using the coding adjustment fast forward as a mechanism to deal with what we think we have said is primarily a function of what

is delivered. Is there a sort of technical reason that that is the best thing to do? Or it just happens that the numbers come out right, or what?

MR. HACKBARTH: Well, I think what Evan said in his presentation is that it is a combination of both. The cost structure has declined due to changes in the number of visits, among other factors, but also the payment levels have gone up due to coding change, which CMS' analysis suggests is not based on changes in the patients but simply changes in coding practice. So the rationale for the coding adjustment is on the payment side. It is not driven by the cost consideration.

MR. CHRISTMAN: I guess the point I would also make is that, you know, sort of the series of questions we went through with George, we did not see the rebasing being practical for 2010, so we went to 2011 with it.

But I think the spirit of the recommendation is that CMS has spread this out, this reduction out over all these years, and, frankly, we don't see any reason to do that. And so sort of putting their policy together with our policy, we are saying don't wait until 2011 for your last year recommendation, go ahead and take it in 2010. And that

will begin to bring payments down moving into the year where the rebasing is taking place in 2011.

You are right in the sense that the reason CMS originally put these reductions in place is different than the things driving our rebasing recommendation. And this is sort of what has made this confusing from the beginning. They both have the same effect obviously. They pull down payment. But, effectively, we are saying -- CMS has decided it wanted to spread this recommendation out. We are saying, you know, don't really need to wait, I think is the spirit of recommendation one.

DR. CHERNEW: I just want to clarify recommendation two, which is the rebasing recommendation. Margins in 2009 were 12.2 percent, so if you thought they were constant and they have looked constant in the past, that is loosely a recommendation. If I understand what rebasing means, there would be a reduction in payment of about 12 percent. Is that the right interpretation?

MR. CHRISTMAN: It is. The catch is that they would probably rebase by combining the -- they might rebase using both the hospital based and the free-standing, and that margin is going to be a little lower than the 12

percent. So if I had to -- you know, back of the envelope, I think it is at least another 5 percent after what we have done in 2010. So I think the payments will come down by 10 percent, roughly, as sort of a lower bound.

I am sorry. There is just one thing, and I went to pains to say this in my presentation. A lot of this depends on inflation and what happens to costs between now and 2011 and what happens when they audit these cost reports. Their actual costs may be much higher or much lower than what we are shooting from right now. So I don't want that 10 percent to get people too excited, but it is sort of, I think, my back of the envelope.

MR. HACKBARTH: Round two, questions and comments.

DR. SCANLON: Now I can say how enthused I am about recommendation three?

No, really, I am, and I think that it is critical. Normally, I think, when we would look at these data for sort of any of our provider types and we see this kind of a distribution, the normal interpretation would be the people that are earning higher margins are more efficient, and the people that are earning lower margins are less efficient; and so, therefore, when we sort of rebase or we reduce the

update, what we are doing is we are encouraging efficiency. And I will borrow sort of Nancy's term. I think what we have to realize here is that we are taking averages of two groups -- care providers and gamers -- and the gamers are probably distributed more in the upper end in the distribution of margins. And so then when we rebase, what we are actually doing is reducing the rewards to gaming, but we are also penalizing the care providers.

And so that is what makes it most critical to move forward with this draft recommendation three, which is to understand sort of what it is that the care should involve and to try and tie sort of the payments closer to the care that is being provided and that we want and expect.

I guess I would encourage either in the recommendation or in the test some kind of a target for timing. You know, I mean, I don't see any reason why sometime in 2010 this study can't be done, I mean like done in the first half so that we could even think about having a new payment system in place by 2012. The world of sort of draft regulations and regulations means that you do need like 18 months' lead time, but we don't want this to linger on sort of beyond anywhere -- you know, on into 2013, 2014,

et cetera, because this is critical in terms of preserving the care that is being provided, I think. Otherwise, if we do start to ratchet down, we are going to be really sort of impacting those kinds of agencies.

MR. HACKBARTH: One approach would be to put a time schedule in. Another approach would be just to make your last point, that we see this as going hand in hand with the rebasing, you need to do these concurrently.

DR. CASTELLANOS: Can you turn on slide 11, please? This slide really bothers me. It goes with Nancy's point and Bill's point about gaming. I mean, this is amazing. We are sitting here and we are looking at it, and we are not making any comments on it. What are they doing? They are going in the high physical therapy and occupational reimbursements, taking care of the patient with home visits and skilled nursing visits really going down. I think there may be some gaming here. I can't believe that the risk of these patients have dramatically increased to account for that.

One of the things that has not been said but was discussed last month when we talked about it is the physician role. Again, there was an analogy with hospice,

and I know we haven't discussed hospice, but I think the physician role is really poorly defined in what his or her responsibility is, her or his participation. What is the role of the medical director? There are certain problems with conflict of interest.

I know in further discussion we are going to talk about that, but I think when we look at things like that, we really need to kind of think about the physician's role and making sure he or she fully understands the responsibility they have.

You made a comment the last time in the presentation about some of the times the doctors are deciding things without knowing what they were doing.

MR. HACKBARTH: I agree with your point, Ron, about physician supervision, or involvement is a better term. As I have said in some previous meetings, I sometimes think that home health is not a service that ought to be paid for separately, that it ought to be bundled with some other service, because it really requires the involvement of clinicians to make sure that what is happening is appropriate to the needs of the patient. And just to say we'll pay for it in a separate silo of its own has always

troubled me.

Just one comment about these numbers. The largest reductions have been in home health aide and social work visits. There was a point in time when there was a lot of concern that the home health benefit was becoming a de facto sort of long-term care benefit, and that too much of the activity was not the therapy or skilled nursing, but home health aide and the like. And so some people might look at these numbers and say, well, this is actually an appropriate readjustment of the sort of care, a desirable readjustment, as opposed to gaming activity. So I think you need to be a little bit careful I how you assess them.

DR. SCANLON: I agree with you on that point to an extent, but, again, it is this question of sort of looking at an average overlooks the fact that we are talking within home health about basically at least two populations.

One is the therapy sort of patient who should be getting better, the expectation is, and more of them are being served through home health, and that is potentially a very good thing.

The second is this very debilitated, sort of potentially deteriorating, potentially dying sort of

patient, different than hospice. And the question is how much skilled nursing or how much home health aide should they be getting, and we don't have any standards for that. And we don't really have good measures in terms of their outcomes either. The best we have is hospitalizations, and there our measures are distorted by the fact that they are mixed in with the people that are getting therapy. So we have got to start to think about segmenting this population to truly understand it.

DR. STUART: I share Bill's concern, and actually it is a question for Evan. It is a little hard to divide this population of providers into caregivers and gamers. Even though I agree with you in general terms, obviously there is some allusion over those two.

My question is: Have you looked at the impact of recommendation one and recommendation two on the for-profit versus not-for-profit?

MR. CHRISTMAN: Well, I think the point I guess I would note is that the not-for-profits in this area still do pretty well. They have margins of almost 12 percent, which is higher than the for-profits in some sectors. And I think that the thing that is difficult to anticipate about our

recommendations is that this industry hasn't been, relatively speaking, under that much cost pressure for the last seven years because our payments have been so high. So we could look at this and say that they have below -- you know, their margins are below 16.6 percent, so their margins will be pushed yet lower by our recommendations relative to the other providers. But we don't know about what they will do in response because, you know, the slide we just had up, you saw that visits dropped by 30 percent.

Certainly there have been changes in the last seven or eight years that, if this industry does find itself under some cost pressure, they may be able to implement to bring down their costs. So it is true that if we are doing an across-the-board cut and not-for-profits are on the low end of the -- or lower relative to the for-profits, that they will get pushed down more. But whether they wind up at an inadequate level is something else.

DR. STUART: I wasn't speaking about the mean. I mean, it is obvious that if you take 8 from 11, I mean, I can compute that. It is more on the distribution. So if you were to look at the distribution of not-for-profits around that mean, would there be a significant number of

agencies that would be at high cost risk?

MR. CHRISTMAN: I haven't looked at the not-for-profits themselves. I guess what I have done is I have looked at the margins of providers with negative margins, and that group, basically it is pretty proportionate to what you see there. It is not disproportionately urban, rural, or mixed, or for-profit or not-for-profit. It is pretty proportionate. The only characteristic that I've seen so far that sticks out is that the agencies with lower margins, the higher proportion of negative margins, tend to be smaller. That is it. But, to my knowledge, the not-for-profits are not a disproportionate number of the low-margin agencies.

MS. BEHROOZI: I guess I just was going to say something about the low end, actually, that you were just talking about, Evan, and that Bill talks about, what are the characteristics in terms of what we want to get out of the benefit at the various ends. And I just wanted to highlight that, you know, comparing it to the last presentation -- and I know we do these things in silos, and it is kind of hard to compare across the silos, not necessarily apples to apples. But, you know, the average margin in SNFs was 14.5;

here it is 16.6. But at the low end, at the 25th percentile in SNFs, it was 5.2. And here at the low end it is 3.1. And, again, given that we don't know what we are getting at that low end, I am very concerned about accelerating the whack, kind of, you know, the take-back on the coding issue.

But, having said that, I really love recommendations two and three, and particularly three, which I think is the kind of thing, the kind of direction that I hope we continue to move in with respect to all of our update recommendations, which is really what is the best way to spend taxpayer dollars on health care. You know, it shouldn't be for too much profit, and it shouldn't be driving the good providers who are providing a lot of service out of business. I really like the corridor concept -- thank you, Bill -- in recommendation three. So I am only comfortable with recommendation one, I think, coupled with this broader approach, and I really want to commend the staff and all the Commissioners who have been working on this for a long time for, you know, coming up with that broader view and encourage us to do it elsewhere.

MR. BUTLER: This is between a round one and a round two, really, but slide 6 says that these are the

Medicare margins. We don't have or I don't think we've seen anything presented -- this is about, as you guessed, 40 percent of their business. We haven't seen anything specifically on total margins, right? Okay. So maybe recommendation three covers this, but maybe it doesn't.

In recommendation two, if you put that, and if you read the chapter, it basically says we are going to set this at the actual cost. It doesn't just say it will take into account the cost in rebasing it. It says you are basically going to have a zero margin. At least that is the way the chapter reads.

So I don't know at this point in time what that means to the impact on the business as a whole. So I think the recommendation would be more likely -- and I realize we focus on Medicare, not the total business. Yet if you are trying to worry about the access issue, to leap all the way to say zero profit is the right goal, I would rather have it say something like we will take into account the costs using rebasing, or something like that, as opposed to say it is just zero profit no matter what. Because we are pretty specific about, I think, that being the recommendation, using the rebasing. At least the chapter reads that way.

If you say just reflects the average cost, and that is not saying sets it at the actual cost, I would buy it. But I think it would be better if you just said takes into account the average cost using rebasing.

I know it is a subtlety, but it is a little different message, I think, at this time than just saying it ought to be zero profit.

DR. MARK MILLER: The thing I would maybe look for your reaction to, like every other PPS system or most other PPS systems, when they get to being created, there is sort of a sense of setting it at an average with an understanding that there is a distribution because, remember, we are talking about an average margin of -- now I am even forgetting -- 12, 15? And, you know, we have a distribution here, both high and low.

So if you are saying, okay, we will set it above the average, you are also saying that there are people who right now under the current payment system are earning, you know, margins that are in the 20- and 30-percent range.

So it is fairly standard when you go into a PPS situation to say, okay, I am going to set it at the average, I am trying to drive behavior around that average to get

people to work towards that average.

I do see what you are saying, and I would argue that even with the reflect, you know, we obviously brief CMS and other people on all this stuff before we do it, and they were asking questions, you know: When you talk about rebasing, what do you mean? You know, what kinds of factors? And I don't think we are saying there is one calculation and you rebase and you are done. There are things that can be considered here in terms of changes in the mix of patients over time. I don't think we are sort of rigidly saying only the average cost. But I would throw that out.

MR. BUTLER: Just one minor rebuttal. The chapter does say it will be set at the cost specifically.

MR. HACKBARTH: That's what I was going to get at.

MR. BUTLER: I just think there's a little bit more wiggle room than that. Not a lot.

MR. HACKBARTH: So what I hear you saying, Mark, is that reflect was chosen with care to suggest something -- it is not necessarily just as arithmetic calculation of what is the average and we rebase at that. And if I heard you correct, if that is the language in the recommendation, then

the text ought to use the same language and be consistent.

DR. MARK MILLER: [off microphone] Before you get too much further down this road -- given the language difference between what you are pointing to and the text, maybe, Evan, do you want to comment?

MR. CHRISTMAN: Yes. I think that this conversation has landed in the right place. Perhaps the language I used in the text was just a little bit too precise. I think the intent is that ultimately the Secretary will come up with an estimate of what the cost of care would be in 2011 based on the most current information they had and a reasonable guess about how the benefit may change. So it wasn't intended to be -- we recognize that we don't want to lock them into some sort of strict formula, and that is not the intent of this recommendation.

MR. BUTLER: Again, if we just stuck to our principle, like in what we just did on SNF, we would say, okay, not only are we freezing it, we are rolling it back 14 percent, or whatever, 12 percent. And, you know, we are not doing that because we are taking the big picture into consideration to some extent. I would like to think that we would be looking at the access issue at the same time we are

looking at the rebasing. But I am sleeping better over it, though.

MR. EBELER: The points have been made. Just I am supportive of the three-part recommendation. I think they tie together well. I think at the core it is rebasing with an interim adjustment in 2010 so that 2011 rebasing isn't a huge cliff. And then three is the longer-term policy recommendation, and I think Bill's point that you want to begin moving that way sooner, you don't want to wait until 2012 before thinking about that, I think is well taken.

DR. DEAN: I think probably some of my concerns have been answered. I, too, was just looking at that 3.1, and I wondered if you had the characteristics, if there was any pattern of the agencies that were in that group. And I guess I was particularly concerned because in my area, agencies tend to be very small, and they tend to serve patients in a very widely dispersed area, so their costs are high. I mean, they may go 20, 30 miles between patients, and so their costs are clearly going to be high, and their margins are going to be low.

I guess I would just hope that -- sure, the number for rural is listed at 14 percent, but there is rural and

then there is rural. And anybody that has struggled with trying to figure out what the definition of rural is will know that there is no reliable definition because usually it is non-MSA, and when you get into western South Dakota, you can go 10 miles between one farm to the next.

So it can be a real challenge to deliver some of these services, and I just would like to be sure that if there is an agency that is really doing that and, in Bill's terms, are really giving care, that they are somehow protected here. But I understand. Basically I support the recommendation. It is just I think we need to have some caution because there could be some very valuable services that get hurt if we get too aggressive.

MR. CHRISTMAN: I think I would just say what I said in response earlier, that it is generally the smaller agencies, you are right; but it is not disproportionately rural/urban. This is not one of those situations where one group dominates like that.

MS. HANSEN: Thank you. Thanks, Evan, for bringing along this far, and my comments are twofold -- one relative to the recommendations, another one to work to be done.

Again, I really appreciate, especially -- all three, but I think Bill and the staff having come up with this whole way of really looking at protecting the care, the actual providers that is reflected in recommendation number three.

I am thinking about the other thing that, Bill, you asked for that I want to underscore again, and that is the kinds of patient groups that do show up for needed home health care. One is the therapy group that does get better, and then so much more. And as many of you are aware, one of my big themes is making sure that people with complex needs are cared for appropriately.

So when I look at the quality-of-care measures that have improved over time, you know, on page 5, and then the comments that have been made relative to the types of skilled visits, on slide 11, the ability to figure out, again, what the outcomes might be for different kinds of groups of patients. And so I don't know that it is so grossly separated to the bolus of people who are more rehab oriented as compared to people who have a great deal of medical complexity that in some ways will -- sometimes may border into the quality metrics of some hospice-like

patients. So, you know, I know we are moving to another silo, but if there is a way that we can begin to think of what are the outcomes that we would expect for quality for the different nature of patients, if more work, you know, is going on in the field itself, that can then begin to get reflected. But it has to do with how do you measure appropriateness and outcomes for different populations.

MR. CHRISTMAN: I think I would just say one thing in that there is some work underway in this area that is looking at different -- like you are talking about, a chronic care group versus a rehab group and so on and so forth in terms of those measures. And we plan to take a look at some of that work, and because it does help to put a better sort of face on those measures, I am hopeful we will be able to get something out of that that will let us turn that presentation around a little bit and go in the direction you are talking about.

MR. CHERNEW: I'm supportive of recommendation one and sympathetic to recommendations two and three, but I still have one concern, and it is basically in the line of what Bill said. I think I can describe it as recommendation two is potentially, depending on how the word reflect is

interpreted, really strong; and recommendation three, which I am supportive of, is somewhat weak in the sense that it requires there to be a study and an assessment to develop methods. So there is going to be potentially some window of time where there has been, if our recommendations were followed, a big cut in payment while we are still trying to figure out how to adequately protect quality, the language that is in three.

The reason I am worried is not knowing a ton about this area, if you have a bunch of efficient providers appropriately paid and a bunch of new gaming providers come in, you will see the margins rise. And if one decides then to cut the margins in one way or another to reflect the average cost where you are averaging across the gamers and the non-gamers, the ones that exit aren't the ones that entered. You end up having a situation where the bad drive out the good, because it might be the only -- and I don't know this to be the case, but you could have a situation where the only way you could survive in this industry with this payment rate is to be a gamer because you have used the gaming numbers that average to drive down payment rates.

And so I am not sure that is going to happen, and

I believe that directionally we are going in the right way, but I am not sure that recommendation three, which I believe is our make sure we do no harm kind of recommendation, is strong enough to really make sure we do no harm, if it ended up that all the good providers were actually the ones that are in the 3 percent and they are the ones that are doing the visits and they are the ones that haven't upcoded and they are the ones that are doing all those things.

So I just don't know enough about the production function to know how this is going to work.

MR. HACKBARTH: Would you put up number three for a second, Evan? Recommendation three.

I agree with your general characterization of three, but I actually look at three as having two parts, one that may be easier than the other. I may be wrong on this, but it seems to me to develop a payment system that attenuates the gains at the high end of the profit distribution and mitigates the losses at the low end is a relatively easy thing that could be done as part of the rebasing process; whereas, the quality indicator thing I think is potentially more challenging and may take a little bit more time.

Based on Bill's earlier comment, you know, what I would think would be very important in the text is to emphasize the link between rebasing and the attenuation of profits and losses, the mixed payment system, and then urge as fast action as possible on the quality indicator piece of it.

MR. CHERNEW: My concern was that if you took this the way that I read it, which is it is basically a study of ways to do these things, and I was concerned that when we get to 2011 and we do this big rebasing, that we study it right now. And depending on the speed and the separateness, you could end up in a situation where your more optimistic vision of the way it all plays out, which I would be very support of, isn't the vision that actually plays out.

MR. HACKBARTH: What I would propose is, rather than try to capture these ideas in the boldface language of the recommendation, that we have some very clear language in the text that talks about the link between rebasing and adjustments in the payment system, to make sure it doesn't come across as, well, rebase now and when you get a chance, to do this recommendation three stuff.

MR. CHERNEW: [off microphone] The problem is the

heterogeneity is captured in the rebasing.

MR. HACKBARTH: Does that make sense to people? Do people feel comfortable with that?

Okay. Nancy?

DR. KANE: I guess I am less concerned about the terrible inequities of rebasing in that the base year that was used, which was 1997, I believe, reflected a different patient population. It was before -- what was it? I forget which one. Maybe it was the Balanced Budget Act -- came in and really eliminated eligibility for the benefit for a lot of the less needy, to a whole set of patients.

So we really are looking at different populations of patients, so I don't know that this is the gaming problem or the fact that the old system was based on people who were much more of the long-term custodial people who just became ineligible after, I think, 1997 or 1998 when the BBA kicked in. There was a huge, there was a million-beneficiary drop, and then a change in who came back in.

So I am not so nervous about the rebasing being sort of even hitting gamers versus non-gamers as it is getting more reflective of who the actual new beneficiary mix is after BBA changed it.

DR. SCANLON: I guess I am very concerned about that. I think --

DR. KANE: Before you interrupt, let me just go one more step. I guess the other piece on two, if we could go back to two, which is the one I was addressing, and to go back to Peter's comment about average cost, one of the things that does concern me about home health and cost is my sense is their capital requirements are like next to nothing, other than working capital; whereas, if you look at a SNF, at least they have a facility. And so, you know, what do they need a whole lot of profit for? is one of my questions. No doubt it is to subsidize their Medicaid and perhaps some of their other uncompensated care pieces. But, you know, I don't think we need to get too obsessed with maintaining a huge profit margin in that their capital requirements are nothing like some of the other types of silos that we set rates for that have much lower profit margins, like hospitals, for instance.

So I guess I am just kind of not too -- you know, I guess I feel like worrying about the profit margin of a low capital intensity industry is just not as much of a concern to me as it might be in a higher capital requirement

industry, a silo.

MR. BUTLER: Just to clarify, that wasn't my point. It was their non-Medicare business and what that looks like. You have got to at least be a break-even overall, or sooner or later you are going to go out of business. I don't think that they need another level of profit to invest. They don't have the same capital needs, you are correct.

DR. KANE: But, again, Medicare is -- I mean, we have as a principle that we shouldn't be setting rates to help us subsidize other payers. I guess I am just less concerned about that.

DR. REISCHAUER: We are trying to ensure access to a set of services, not the institutions that are providing it now. And there doesn't seem to be any problem about sort of institutions coming into this area.

DR. SCANLON: I guess my concern is that if you take recommendation two and you were to rebase solely on the basis of total costs, and the current margin is averaging 15 percent, you are going to take this distribution and you are going to reduce the payments by 15 percent. That is going to take the agency that is providing care and earning a 4-

or a 5 percent margin into negative territory. It is going to take the agency that is making 40 percent today, and they are going to make 25 percent tomorrow. That doesn't seem to me to be a good use of public funds to preserve a system where an agency is making 25 percent. And how they are making 25 percent? The concern in this situation is that they are making 25 percent not by being more efficient, just by not visiting the people in their homes.

DR. KANE: Well, I think what you are saying is don't just use whatever people -- don't use the average cost, but try to look at why the costs are different.

DR. SCANLON: But, see, recommendation two involves making a rebasing decision in the current structure; whereas, recommendation three says let's change the structure of the reimbursement. And so you don't accomplish what we want in terms of redistributing the money unless you go to recommendation three.

And I agree with Glenn. You can do a version of recommendation three with respect to the corridors and everything very, very quickly. All you have to do -- I mean, the structure is easy to lay out. You have to come to some agreement on what the parameters are going to be, and

there is both sort of policy and sort of political decisions that go on there. But it is, you know, technically very, very feasible.

We went from passing the Balanced Budget Act in 1997 to the Interim Payment System in 1998, so, you know, you can make changes, I think, of this magnitude in a relatively short amount of time.

MR. HACKBARTH: So, Bill, what I have suggested is that that link that you have been talking about is, in fact, important and that we highlight it in the text. Are you satisfied with that approach? If not, what would your alternative be?

DR. SCANLON: My only alternative would be to say that we go to three immediately, I mean, as opposed to doing two, because I think that we want -- and I would moderate two from where Peter was. Rebasing to me is that you decide, okay, here is what the pie is and how we are going to cut it up. And the pie in the past has been sort of budget neutrality. Well, we don't want to do that because it is 15 percent profit build into a budget-neutral pie. We don't necessarily need to go to a zero profit pie. We could go to a 5 percent average pie and divide that up as

rebasing.

So there are variations of this that are less problematic, but the most ideal is to go to three, but I understand how radical it is.

MR. HACKBARTH: Let me just pursue this for a second. When you say do three right away, you are talking about the blended payment system part of three.

DR. SCANLON: Right.

MR. HACKBARTH: One way to do this -- and, again, my preference is just to try to capture all this in the text. But one way to do it would be to say concurrent with rebasing, do the blended payment thing, and then have number three be also develop quality indicators.

DR. SCANLON: Yes, three in my mind involves implicit rebasing because basically when you set those parameters to do blending, what you are going to be doing is you are going to be having targets in terms of what the overall pie is supposed to be.

MR. HACKBARTH: Reactions to that? Take the blended part of part three and move it into two.

MR. CHERNEW: I like this discussion. I think in some ways, Bill, you are looking at three the way I look at

my kids, which is it is kind of better than it is. By that I mean three is now a recommendation about study; it is not a recommendation about rebasing or changing payment rates or doing anything. The idea of blending three and two so you do them sort of simultaneously is more -- when you speak, you speak as if it is kind of blended, that you are both rebasing and changing payment forms simultaneously. That is the way you talk about what it is. But if you read what it is, that is not what it is. And that could be done -- I am fine with that being in the text.

MR. HACKBARTH: I am really worried about the time, so let me ask Evan and Mark whether they see some problem with taking what I've referred to as the blended payment part of three and move it into two, so two would say, in essence, concurrent with rebasing, do the blended payment; and then three would be work to develop the quality indicators. Is there a problem with that approach, Evan and Mark?

MR. CHRISTMAN: I don't see anything conceptually wrong with it. I think you could do those.

DR. MARK MILLER: The reason that I am more of the mind to try and be clear that we would like two and three to

occur concurrently but not say do a blended payment as part of two is we haven't, either as a Commission or as a staff, kind of thought through, well, what do we mean, we are blending there. And I understand in some of your articulation of this, I think in your mind you have a sense of how you would do it. I think you would go at it on the basis of profit. I don't think there has been a widespread discussion here among ourselves or among the staff.

What I am, however, comfortable with is to say we are really looking for a rebased payment in 2011 and a more intelligent payment system to deal with some of the problems that people have talked about here, whether it is gaming or concern about a certain type of patient not being treated, which in some ways are the same thing.

MR. HACKBARTH: The practical question that needs to be answered is: Well, what if developing the blended payment system with the quality indicators takes longer? Is MedPAC's position that the rebasing ought to wait until those pieces are ready to go concurrently? That is the question I would ask.

DR. KANE: Couldn't we also suggest that they rebase but implement it, you know, over a three-year period?

I mean, I thought by blending you meant blending what we are paying now with what we think we should be paying based on the actual cost and that you are blending that kind of, you know -- what do you mean by blending? Because, to me, you could say rebase and implement it over a three-year period.

DR. SCANLON: What we are talking about in blending is either what Newhouse has called the partial capitation model, what I call sort of risk sharing. I mean, it is the issue that we would set kind of a norm for profit, and then people would be allowed to make somewhat more than that, but once they went beyond that excessively, then we would reduce it. And we would also have some protections on the downside. It is the same thing that we have been doing in Part D in terms of risk sharing.

So why I am confident that this can be done is that we have done it in D, we have done it sort of in the Medicaid programs in all kinds of instances, where we say we are going to give you money, but we are also going to look at your costs, and we are going to have kind of -- well, to get to their profits, you have got to look at their costs, right? I mean, we're looking at sort of the difference between the money we paid them and their costs. I mean,

that is the profit measure.

MR. HACKBARTH: I feel like we are spinning our wheels a bit here, and we need to move on. What I propose we do is leave the recommendation language as is, but make it crystal clear in the text that what we envision is that the rebasing and the blended payment happen concurrently.

DR. SCANLON: And that the quality measurement development can be later than that.

MR. HACKBARTH: Right. Okay. We don't need to repeat it. I am with Bill. I don't think it is necessarily all that complicated to do. Okay. So that is the approach to this.

I have lost track of whether we were on round two or round one. I think we are ready to vote. Is there anybody who is not ready to vote yet?

Okay. On recommendation one, all of those opposed to recommendation one, please raise their hands? All of those in favor of one? Abstentions? Was that a delayed -- okay.

Recommendation two, all those opposed to number two? All in favor of number two? Abstentions?

And number three, all opposed to number three? In

favor? Abstentions?

Okay. Thank you, Evan.

Next is inpatient rehab facilities. Go ahead, Kim.

MS. NEUMAN: Next, we're going to look at inpatient rehabilitation facilities, or IRFs. I am going to briefly recap some of the data on IRFs that we presented in December and provide some additional information in response to some of your questions. Then we'll have the Chairman's draft recommendation for your consideration.

First, though, I'd like to thank Hannah Neprash for her work on this presentation.

The first slide provides a couple of key background points on IRFs. The Medicare fee-for-service program spent $6 billion on IRFs in 2007 with fee-for-service beneficiaries accounting for over 60 percent of IRF patients.

The 75 percent rule has been one of the most significant factors influencing IRF services in recent years, so I'm going to recap it briefly. As you will recall, historically, 75 percent of a facility's patients were required to have certain specific diagnoses in order

for the facility to be paid as a IRF. After CMS discovered that many IRFs were not in compliance with the rule, they made some changes to the rule beginning in 2004. They limited the types of hip and knee-replacement patients that would count toward the rule. They also renewed enforcement of the rule beginning in 2004 with a phase-in of the compliance percentage from 50 percent to 75 percent over several years.

Before the phase-in was completed in December of 2007, the Medicare, Medicaid, and SCHIP Extension Act of 2007, or MMSEA, permanently capped the threshold at 60 percent retroactive to July 1, 2007, going forward. For ease of reference, I will continue to refer to this rule as the 75 percent rule in this presentation, since for most of the analysis period, IRFs were under the impression that the threshold would eventually reach 75 percent.

Next, we will take a quick look at the available data on IRFs. First, supply of facilities. The first line in the chart shows that the number of IRFs increased modestly between 2002 and 2005 in the initial years of the PPS and has decreased modestly since then with the renewed enforcement of the 75 percent rule. We see a fairly similar

trend in the number of IRF beds, with a modest increase in the total number of beds from 2002 to 2004, and then a modest decrease from 2004 to 2007.

The decrease in the number of IRF beds since 2004 has been less than the decrease in the number of discharges, suggesting that capacity remains adequate to meet demand. In fact, between 2004 and 2007, the aggregate IRF occupancy rate has declined from 67 percent to 61 percent.

In the December meeting, Jennie and Glenn, you both asked about the geographic distribution of IRFs. This slide shows the location of IRFs throughout the United States. In 2007, every State had a least one IRF. There were more IRFs in some areas of the country than others, however. There tend to be more IRFs in the Eastern and South Central portions of the United States.

The next slide shows the number of IRF beds per 100,000 Medicare beneficiaries, which provides a measure of IRF capacity relative to the size of a State's Medicare population. Most States had between 51 to 110 IRF beds per 100,000 Medicare beneficiaries. The States with the two darkest shades on the map had more beds than this, while the States with the lightest shade had fewer.

Next, volume and payment. After an increase in fee-for-service volume in the early years of the PPS, volume has decreased since 2004 with renewed enforcement of the 75 percent rule. Some of the decline in Medicare fee-for-service volume is the result of increasing Medicare managed-care enrollment.

Controlling for the change in the fee-for-service population, the top line of the table shows an average decline in Medicare fee-for-service volume of about 7.5 percent per year between 2004 and 2007. The decrease in volume has slowed in 2007. Volume declined on average 9 percent per year from 2004 to 2006, and 5 percent from 2006 to 2007.

While volume declined, Medicare payments per case increased as IRFs treated fewer hip and knee replacement patients who tend to be less complex and have lower reimbursement.

This next chart shows you the shift in the mix of patients that's occurred. Hip and knee replacement cases, which were the most common IRF cases in 2004, have declined substantially, falling to the third most common type of case in 2008. Stroke has become the most common IRF case and

fractures of the lower extremity or hip fracture have become the second most common.

To understand what the decline in fee-for-service IRF cases has meant in terms of access to care, we've looked at hospital discharge patterns to post-acute care settings for hip and knee replacement patients as well as other conditions frequently admitted to IRFs.

What we've seen with regard to hip and knee replacement patients is that as the share of hospital patients discharged to IRFs has declined, we've seen a corresponding increase in discharges to home health and SNFs. This data suggests that hip and knee replacement patients previously treated in IRFs are receiving care in other settings. It does not, however, tell us whether outcomes have been affected by the shift in site of service.

On that front, CMS's post-acute care demonstration, which is fielding a common patient assessment instrument across post-acute care settings, may provide some insight. A CMS report to Congress on the demonstration is due in 2011.

Now, onto quality. As you will recall, to measure quality, we look at an indicator commonly tracked by the

industry, the functional independence measure. We look at the functional independence gain, or the FIM gain, between admission and discharge to measure quality. From 2004 to 2008, we see an increase in FIM gain, suggesting improvements in quality. However, these data are not risk-adjusted for changes in patient mix, so we have to be cautious in interpreting them.

Moving next to capital, as mentioned in previous presentations, access to capital has tightened in 2008 due to economy-wide issues in the credit markets. These changes in the credit markets are broad and not related to specific changes in Medicare payment policy. Nonetheless, economy-wide issues in the credit markets may result in increased capital costs or delayed capital investments for IRFs.

Now, looking at payment and costs, they tracked each other closely prior to the PPS. Following implementation of the PPS, we initially saw payments grow faster than costs, but with implementation of the 75 percent rule in 2004, growth in costs per case accelerated as IRFs began to treat fewer patients with less complex conditions who did not meet the rule. Cost growth has slowed some in 2007, suggesting that adjustments to the 75 percent rule are

leveling off.

In terms of margins, the aggregate Medicare margin increased substantially after implementation of the prospective payment system, reaching nearly 18 percent in 2003. Medicare margins have declined modestly each year since then.

The aggregate Medicare margin in 2007 was 11.7 percent. Margins vary by type of provider. For example, freestanding and for-profit IRFs have particularly strong Medicare margins, 18.5 percent and 17 percent, respectively. Nonprofit and hospital-based IRFs have lower but still favorable aggregate Medicare margins of around 8 to 9 percent.

Peter, you asked why hospital-based IRFs have lower margins than freestanding IRFs. Economies of scale appear to be one factor at work. Hospital-based IRFs have, on average, a smaller number of discharges and lower occupancy rates than freestanding IRFs. If we look at margins by size of facility, we see that margins are higher for larger facilities than smaller facilities, suggesting economies of scale is at least a partial explanation.

The aggregate Medicare margin for 2009 is

projected to be 4.5 percent. This represents a decrease from the estimated 2007 margin of 11.7 percent. The projected decrease is due almost entirely to the zero update for the last half of 2008 and full year 2009 enacted by MMSEA. It is important to note that these margin projections do not assume any increased cost control efforts by IRFs in response to MMSEA's negative updates or the recent declines in volume. To the extent that IRFs restrain their cost growth in response to these changes, the projected 2009 margin would be higher than we have estimated.

To summarize, facilities and beds declined modestly in 2007. Volume and spending declined, as well, while payments per case increased. Access to care appears to be adequate, but is complicated to assess. In terms of quality, there has been an increase in functional gain over time that case-mix changes prevent definitive conclusions. The 2009 projected margin is again 4.5 percent.

So with that, we have the draft recommendation for your consideration. It reads: The update to the payment rates for inpatient rehabilitation facilities should be eliminated for fiscal year 2010.

The implications are a decrease in spending relative to current law, estimated to be between $50 million and $250 million in one year and less than $1 billion over five years.

In terms of beneficiaries and providers, there may be increased financial pressure on some providers, but overall, we would expect a minimal effect on providers' willingness and ability to care for Medicare beneficiaries.

With that, I will conclude our presentation and look forward to your discussion.

MR. HACKBARTH: Clarifying questions for Kim?

DR. STUART: It may just be me, but I found it confusing to think of the 75 percent rule as a 60 percent rule. I can understand why you did it, but because the 75 percent rule was never actually implemented -- well, it was for about six months, but then it was undone. So when I get near the end of the chapter and I see the 75 percent rule, I just have to say 60 percent.

And then I'm beginning to think, well, maybe it should have been 75 percent. And so part of my question is semantic. But the other part is what would have happened had this rule actually fully been implemented?

MS. NEUMAN: Well, I think if it had been fully implemented, there would have been continued shifts in the type of patients treated by IRFs, as we've seen in some of the data. I think there would have been a continuation of that.

In as far as what is the right number, I think that that is an open question. One of the things that MMSEA did was require that CMS do a report to Congress--it's due this summer -- where they'll look at the impacts of the 75 percent rule and consider whether they are alternatives to it. So that is a venture that is going forward.

MR. HACKBARTH: Isn't the tricky part of answering Bruce's question what institutions do in terms of adapting to this presumably smaller volume? If you went to the 75 percent rule, they would be focused more on a smaller group of patients. So the question becomes how quickly do they adjust their staffing and other fixed and semi-fixed costs in response to the new market that they face. That's sort of the tough thing to predict.

MS. NEUMAN: Right. There's definitely questions about how quickly they can adjust their cost structures and adapt to the changes in the patient mix.

As we saw in these shifts of patients, what has happened largely is not that they're taking more stroke patients, it's that they're taking less of the patients that don't meet the 75 percent rule. It's sort of adapting to that new dynamic in their cost structure.

DR. CHERNEW: What do we know about the quality of care in IRFs versus quality of care for comparable patients outside of IRFs, and the quality of care for non-qualifying patients in and outside of IRFs? In other words, we talk about -- we always do this by providers, but I'm just curious as to if you didn't go there, where would you go, how would it be, how would your care be?

MS. NEUMAN: That's a big question that's still open to research. There's a number of --

DR. CHERNEW: [off microphone] It's something I want to know but [inaudible].

MR. HACKBARTH: It is sort of the $64 million -- billion -- question in post-acute care and work is underway to try to get better answers to it. That's the short answer.

MR. GEORGE MILLER: Just a clarification. On the slide 15, do you have the breakdown of the range by

percentile of the not-for-profits and for-profits like you did for all IRFs up at the top? What's the variation in the 25th to the 75th?

MS. NEUMAN: You want that for for-profit versus not-for-profits?

MR. GEORGE MILLER: Yes, just like you did up above.

MS. NEUMAN: Yes, I do have that. For the nonprofits, the 25th percentile is a minus six, and the 75th percentile is 18. For the for-profits, it's the 25th percentile is minus three and the 75th is 22.

MR. GEORGE MILLER: Thank you.

DR. KANE: On page 10, do we have a sense -- this is the distribution of total hip and knee replacement when they stop going to -- when fewer go to IRFs and more go to--do we have a sense of what the payment change is between 2004 and 2007 as a result of the number shifting from IRF to SNF and home health, because I think that would sort of help us think about whether it's a good thing or a bad thing to have this redistribution.

MS. NEUMAN: We do not have an estimate at this point of the cost differences.

DR. KANE: Payment. I mean payment, the Medicare payment.

MS. NEUMAN: There's sort of a twofold answer to that. There's just the difference in payments to IRFs versus the difference in payments to SNF, assuming they go nowhere else. And then on top of that, there's the question of where do they go next for post-acute care and does that differ depending on which setting they started in and how does their whole sort of series of payments look like? Unfortunately, the short answer is that we don't have a definitive cost estimate right now, but it's something that we've thought about looking at.

DR. REISCHAUER: You could do this with an episode grouper, right?

MS. NEUMAN: Yes, you could consider an episode grouper.

MR. LISK: Yes. I mean, what you do see generally, in general patterns for the hip and knees is the SNF -- the stay in the SNF is longer than it is in the IRF. Both frequently end up using home health afterwards. The readmission rates back to hospitals end up being slightly higher in SNFs, being a little bit higher in SNFs than in

IRFs, although that is in general on average, but we'd have to control better for the differences in the patient mix to really definitively get at that. So that's the general thing. It's complicated.

MR. HACKBARTH: Any other round one clarifying questions? How about round two comments, any?

DR. KANE: Just to kind of comment on the answer to my question, it seems that that's fairly important to know. I mean, that's the whole point of having a 75 percent rule, I assume, is that the assumption is some of these patients shouldn't be going to IRFs and there's a reason. That seems like low-hanging fruit, using the episode type of methodology to just say, is it at least less or more expensive, and then the other issue is does it take longer. And then a third issue is, is it a better or lower functional outcome.

If we can't get at the third one, it doesn't mean we shouldn't answer the first two, and I think we have the data to do that if we -- I think it would be really helpful for me to know going forward, should we continue to support the 60 percent or whatever rule or should we say it had the wrong effect and we should drop it?

DR. CASTELLANOS: Just listening to your comment about remission rates, I guess as it applies to slide 10, you said there's less remission rates with the IRFs, is that what you said?

MR. LISK: In general, it's a little bit less than SNF, but there's differences in the patient population. The population that generally goes to the SNF has been historically a little bit older and stuff, so therefore also more likely to be readmitted. Some other --

DR. CASTELLANOS: Is there a stinting problem or is that a 60 percent problem or is that a what problem?

MR. LISK: It could be a combination of things. You have to remember, an IRF is a hospital, so certain complications they might be able to treat that a SNF is not capable of treating, so therefore you may have higher readmissions under the circumstances.

MR. HACKBARTH: Yes, I would think that that would be at least part of it. You've got greater capabilities in the IRF that allow you to avoid some readmissions that others could not.

MR. LISK: I mean, there are cases where SNFs do not necessarily have RNs 24 hours and where the IRF would

licensed have to, in certain patients, certain circumstances, might require 24-hour nursing in certain circumstances. So that would be one reason.

DR. CASTELLANOS: Isn't it true with IRFs that you do have some risk-assigned patients there, over 85, bilateral hips, and body mass? So doesn't that take something out of that?

MR. HACKBARTH: Even for those, they're required to go to IRFs, but there are exceptions in the 75 percent rule, right. Kim, did you have something on that?

MS. NEUMAN: No.

MR. HACKBARTH: Okay. Other round two comments?

MS. HANSEN: Again, I think maybe to your point, Ron, is just who the patient profile is makes such a big difference in terms of the use of the resources. And it is on complexity and cognition, as well, too, because I think sometimes that is kind of one of those third-rail factors that oftentimes I don't how one measures. But frankly, having worked with the population for 25 years, I just know that that will vary oftentimes the kind of setting and resources that you do. So the grouping then has to be looked at more carefully, but again, that's kind of the big

question as to what that appropriate profile is.

So I don't know, whatever work we can do with some of the quality folks and looking at the risk adjustor-type profile, that seems to be an important factor as to whether or not you can go to a home health agency. Or if you're a 60-year-old person who is fairly healthy with no cognitive issues, going to something that's quick and with no likely readmission versus somebody who's got multiple conditions and is very forgetful about treatments, the readmission risk is going to be higher.

So I don't know how one captures that, but then you can, I think, do the dollar episode comparison as a result. But it should hopefully be more apples to apples then.

MS. NEUMAN: Just to comment on that, that is sort of one of the challenges in the research that has been done in this area, trying to compare costs across the settings, is are the patients in the different settings comparable and you can you ever control for that accurately or adequately?

DR. MARK MILLER: Even with the episode stuff, which was back over here, I don't know that these adjustments always kind of rise to it. We found some really

interesting things between hospital-based SNFs where there's this assumption of much more complex and more intense patients, but when you got underneath some of the case-mix adjustment and looked at the patient, they actually tended to be younger. They had family to support them. They were assessed to be likely to recover faster. And so there were some really intense selection issues that were occurring, coupled with the notion that we're talking about what's really a hospital. So the remission kind of gets blunted because we're already in a hospital setting.

The other thing I'll say about this is at this time -- this is now dated, of course, but at the time of the 60 or 75 -- Bruce, now you've really got me all screwed up -- at the time of the 75 percent rule, dammit, and it was a 75 percent rule then, we were concerned about this. We got a physician consultant and put a bunch of physicians on the phone who did this type of thing and had this discussion about these types of patients, hips and knees, and what's going to happen, and had that kind of conversation. There was a lot on the phone of the world is falling apart, you've got to put these patients in. It was interesting, because there was one physician on the phone who said, actually, I

live in--and I can remember where--and we don't have these. I have designed for hip and knee replacements an entire program that revolves around the home health setting. You do exercise before. And he said a bunch of other things that I'm not able to reproduce here. He said, I don't use these at all and I'm willing to say to anybody on the phone that my patients' outcomes are as good as anyone else's.

It's kind of a complicated area. In addition to the risk adjustment, it's very hard to get at these things.

MS. HANSEN: And I actually would concur with his experience. Even in our PACE program, sometimes we have found people, even with cognitive problems, being in the hospital environment, whether it's IRF-like, it's iatrogenic and it creates more secondary problems. So bringing them out to a more normalized setting, say a home health -- they're in a home setting, the recovery rate was incredibly fast. So these are, again, clinical applications, but not easily measured research-wise.

MR. HACKBARTH: Any others? Ready to vote? Would you put the recommendations up on the screen, Kim?

So all opposed to the proposed recommendation, please raise your hand? All in favor? Abstentions?

Okay, thank you. Good work.

And last is long-term care hospitals.

MS. KELLEY: Good afternoon. Today I'm going to answer some questions asked last month about RTI's recent analysis of LTCH use, and then we'll review our findings on payment adequacy for LTCH services, and then you'll discuss the Chairman's draft recommendation.

So, first let me address some questions that Bruce and John asked last month. You both asked about how use of services in Medicare payments for medically complex patients differed in areas with LTCHs compared with areas without. As we discussed in December, this is something MedPAC looked at a few years back, using 2001 data.

You'll recall that, after the Commission recommended the development of patient and facility criteria for LTCHs in 2004, CMS contracted with RTI to study the issue. RTI analyzed LTCH, acute care hospital, and post-acute care claims data from 2004. So, this is more recent then the work that w did. And I'll review some of the major findings from RTI's analysis.

RTI found two important factors that predicted LTCH admission. The first was severity of illness. Having

an APR-DRG severity score of four more than doubled the probability of an LTCH admission relative to having a severity level of two.

A second strong predictor of LTCH admission was whether the beneficiary lived in a state where many LTCHs were available. Patients in high LTCH states such as Louisiana, Massachusetts Indiana, Michigan, Pennsylvania, Ohio, Texas, they were almost three times more likely to be discharged to a LTCH, and these findings were consistent with MedPAC's earlier findings.

RTI also found that, all else equal, having an LTCH admission was associated with a shorter acute care hospital stay by about one-and-a-half days, suggesting that LTCH care may be substituting for some of the later days of an acute care hospital stay. Again, our earlier analysis observed the same phenomenon.

RTI also looked at LTCH's per-case margins and found that they varied substantially across DRGs, even after stratifying to remove the effects of high-cost outlier payments and short-stay outlier payments. This variation in profitably stemmed from bias in the DRG weights which caused systematic understatement of cost for cases using relatively

more ancillary services.

And so, then, getting specifically to the questions that were asked, RTI look at areas with LTCHs to examine differences in costs and outcomes between ventilator patients who were transferred to LTCHs and those who remained in acute care settings. The analysis focused on these patients because a diagnosis of tracheostomy with at least 96 hours of acute care ventilator support is the strongest clinical predictor of LTCH views.

RTI's findings may suggest that went less complex patients are transferred to LTCH's, they have higher Medicare payments per episode and similar or worse outcomes than clinically similar patients in the same area who do not use LTCH services. But the most complex patients appear to have better outcomes in the LTCH and the same or lower per episode payments. So, complexity really matters. Although there are some limitations to this type of analysis, the findings tend to support those of the Commission.

Finally, RTI matched four market areas with LTCH's to four without to determine if there were area-level differences in episode outcomes among clinically similar ventilator patients. This analysis found that LTCH supply

may be associated with fewer days per episode for ventilator patients, but there appear to be no impact on Part A cost per episode, and there also appeared to be no impact on rates of mortality or readmissions.

The results of the study led RTI to make several recommendations for identifying appropriate LTCH cases and payment levels, some of which are listed here. I won't go to them item by item, but will just point out that some of RTI's recommendations echoed those the Commission made earlier, specifically the recommendation to require LTCH admissions to have certain medically complex conditions, and the recommendation to establish specific facility criteria as conditions of participation.

Finally, RTI argued that one of the major issues at hand is whether LTCH and short-term acute care hospital payments are appropriate for medically complex patients needing intensive treatment programs. As a result, RTI recommended that CMS conduct additional research to examine the adequacy of payments for these patients under both the LTCH and the acute care hospital PPSs.

In addition, RTI raised conditions that both hospitals, both short-term acute care hospitals and LTCH's,

might be unbundling services for which they've already been paid and discharging patients to the next level of care, and RTI recommended that more research be done on this as well.

And it's not up here on the slide, but I have one more question to address. George, you asked how many hospitals within hospitals are owned by other companies rather than the hospital they are located in. Slightly more than half of all LTCHs are hospitals within hospitals and, by our estimate, about half of hospitals within hospitals are owned by other companies, notably Select Medical Corporation.

So, now, let's turn to our review payment adequacy. I'll summarize the results of our analysis of supply, access and volume, quality, access to capital, and payments and costs.

First, we found, as you can see here, that supply has stabilized after a period of rapid growth.

This slide shows that growth in the number of LTCH cases per fee-for-service beneficiary has been fairly stable, suggesting that access has been maintained. It's not shown here, but growth in payments per case has slowed markedly but remains positive, while length of stay

continues to decline.

Turning to quality: last month we presented our finding that readmission rates and rates of death were stable or declining for most of the top 15 LTCH diagnoses; This was a good finding. This month we also looked at four hospital-level patient safety indicators developed by AHRQ, decubitus ulcers, infection due to medical care, postoperative pulmonary embolism, or deep vein thrombosis, and postoperative sepsis. We found that there were fewer cases of infection due to medical care and postoperative sepsis in 2007 compare with 2006. At the same time, however, there was a small increase in the number of cases with decubitus ulcers and postoperative PE or DVT. As always, we're cautious about relying on the results from our analysis of patient safety indicators, as these indicators were developed for acute care hospitals, not LTCHs.

We found that access to capital varies across the industry but generally has tightened across the board. This, of course, reflects economy-wide issues rather than Medicare payment adequacy. At any rate, you will recall that the Medicare, Medicaid and SCHIP Expansion Act of 2007 placed a three-year moratorium on LTCH growth, so the need

for capital may be limited.

Overall, the 2007 margin was 4.7 percent. Our predicted margin for 2009 is 0.5 percent. This is because, in the absence of behavior changes, we expect that cost growth in 2008 and 2009 will outpace payment growth despite some payment relief included in MMSEA.

Moving onto the draft recommendation you discussed last month. It reads as follows: The Secretary should update payment rates for long-term care hospitals for Fiscal Year 2010 by the projected rate of increase in the rehabilitation, psychiatric, and long-term care hospital market basket market, less the Commission's adjustment for productivity growth. Under current market basket assumptions, this recommendation would update the LTCH payment rates by 1.6 percent.

The Secretary has discretion to update payment rates, but CMS has stated its intention to use the market basket as a starting point for establishing updates to LTCH payments. Thus, a recommendation of market basket minus productivity will produce savings relative to a market basket. This update is not expected to affect providers' willingness and ability to care for Medicare beneficiaries.

So, I'll be happy to answer any questions you might have.

MR. HACKBARTH: Round one clarifying questions for Dana?

MR. GEORGE MILLER: Just briefly -- first of all, thank you for answering the questions. And I wrote the numbers down, but I guess I'd like to draw the analogy to the question about the percentages of hospitals within a hospital. If I remember the numbers you gave, there did not seem to be a correlation with ownership of the hospital with the -- the parent company with the hospital. Do I have that correct, that most of the hospitals within hospitals are owned by someone else?

MS. KELLEY: About half of the hospitals within hospitals are owned by someone else.

MR. GEORGE MILLER: About half? Okay. Thank you.

MR. HACKBARTH: Other clarifying questions? How about round two comments?

DR. KANE: Just to be consistent with my other comments about home health and some of the other ones, I know we've suggested that there should be some kind of way to assess function and all of that. It's just very

frustrating to not know anything about the difference in costs or outcome of who goes for an LTCH versus who doesn't.

Is there anyway, again, to use the episode grouper to come up with common diagnoses for LTCH's, ventilator dependent people, and just see what the differences in outcome and cost are when they go to LTCH versus the many people who are probably not in LTCH market areas and what their cost differences are?

I just feel that we do have some data and we don't seem to be using it, and I understand the differences and difficulties of adjusting, but I don't get a sense of what the value added and I really think we need to have a better handle on that, of an LTCH versus just an acute care say.

MS. KELLEY: I do think we have some information about how costs differ, the outcomes based on the work that RTI did and that the Commission did earlier. What we don't have is good outcome and quality data.

DR. KANE: So what are the cost differences?

MS. KELLEY: Well, precisely.

MR. GEORGE MILLER: To follow up on Nancy's comments, does not AHRQ or the Joint Commission have quality standards for these?

MS. KELLEY: Long-term care hospitals have to meet the same requirements that acute care hospitals meet. They are certified as acute care hospitals.

MR. GEORGE MILLER: So, those quality measures, are they not applicable here? Did you say that you were hesitant to use MedPAC's quality data?

MS. KELLEY: No, we used AHRQ's patient safety indicators, but they were developed for acute care hospitals.

MR. GEORGE MILLER: Okay. I see. Oh, that was the correlation?

MS. KELLEY: Yes.

MR. GEORGE MILLER: Okay. Thank you.

DR. REISCHAUER: You said half of the hospitals within hospitals are owned by somebody else. Are these chains that own them for-profit chains?

MS. KELLEY: Yes.

DR. REISCHAUER: So, they would have them in various other hospitals?

MS. KELLEY: Yes.

DR. MARK MILLER: Just to Nancy's point, if I understood the exchange, and I've been missing a lot of

balls today, so, I'm going to -- a few years ago, when we did this analysis, we did look at the difference in cost between beneficiaries who use this as part of their episode, versus use LTCH's, versus others. We found, just to your -- and again, with lots of caveats on knowing the outcomes and all of the rest of it, that's what led us to our conclusion that if you're into the severity level three and four types of patients, this made more sense for patients like that to go there, but at the lower levels, not. And that's similar, or the same, or thereabouts, to what RTI has just come up with.

MS. KELLEY: Yes, that complexity really matters and that costs really equalize with the very high severity patients. But I think the main caveat would be that the only control for outcomes in quality that we have -- the only way we were able to look at outcomes was using readmissions a mortality rate. We don't have anything more specific than that. I assume that you're talking about something a little more detailed.

DR. KANE: Yes, kind of the overall episode.

But also, if they were to only do these higher complexity patients, what would that do to their occupancy

and their ability to cover their fixed costs? I guess it's like the IRFs. We just drove their occupancy down from 67 to 61 percent, and these are high fixed-cost businesses. So, I'm just curious to know a little bit more about what the range of --

DR. MARK MILLER: If I could pick up there. So, for the last several years, our sets of recommendations of focusing it on the high acuity patients have been discussed in great detail in the industry and CMS, and the industry agrees that to focus should be on the high complexity patients.

Also, you will remember -- and you, too, because I'm pretty sure you were here when some of this discussion when on, and this is one thing that we want to look at. Nick used to argue that, because of what you just said, we -- as a policy, may want to start thinking of these as referral. It may not be that you want -- some of the frustration with these things is, when they were growing, they were growing in the same marketplaces. For what you're pointing to -- is this may be a very select population. And so, some of the policy questions we been asking ourselves in thinking about going down this road is, should we start

thinking of these as referral areas for precisely the reason that you're saying, because there should be a relatively small segment of the population? Sorry.

DR. BORMAN: Just to follow up on what Mark just brought up, my own experience with this relates mostly to an area where the access to tertiary care is somewhat more constricted.

In order to allow those resources to be utilized most effectively, the LTCH was often the vent, if you well, from the acute care hospital, and primarily for ventilator-dependent patients.

And I heard some of the presentation correctly -- and it was a very nice presentation -- defined as I could follow it, a lot of this does indeed circle around the ventilator-dependent patient. And they are almost by definition going to be in that high severity, whatever, level group. So, maybe there is a natural experiment comparison here since there is this geographic focus of LTCH that we -- an analysis limited to just that group, that is, the failure-to-wean group perhaps winnowed down by a couple of diagnoses on a geographic basis. Obviously, you have to control for some of the wage and some of the other economic

geographic variation, might be somewhat informative in terms of believable outcome comparison for those two groups by defining it fairly slickly in that way.

MR. HACKBARTH: Other round two comments? I think we're ready to vote then.

All opposed to the recommendation, please raise your hand? All in favor? Abstentions?

Thank you, well done.

We will conclude with a public comment period.

Seeing none, we are adjourned until 9:00 a.m. tomorrow.

[Whereupon, at 4:30 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, January 9, 2009.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 9, 2009
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
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JOHN M. BERTKO, F.S.A., M.A.A.A.
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ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: We have two topics today, hospice and Medicare Advantage. And on the hospice issue we will be discussing and voting on recommendations.

Kim, are you leading or is Jim leading? Jim?

DR. MATHEWS: Good morning. Today we will be following up on information on Medicare's hospice benefit that we presented in November of last year. We have some additional qualitative and quantitative analyses for your consideration and some revised draft recommendations.

Before we begin, I wanted to highlight some of the more significant changes to the document that we've made in response to your comments at the November meeting.

Karen, who is not here today, asked for some additional context material and we've added this both to the introduction and at the conclusion of the chapter.

Nancy and Bill, you asked for more information on the basis for setting payment weights under the revised system. We've discussed this by phone in the interim, but to help you assess the impacts of one set of weights versus another, we've included the full impacts of the two sets of weights on pages 18 through 20 of the revised chapter.

We've also changed the date certain for implementation to reflect the need for additional data collection and evaluation.

Mike, you asked for more information on potential behavioral responses by providers under the new system, and we've added this to pages 20 through 23.

Jack, George and Peter, you asked for additional breakdowns of types of hospices with the number of beneficiaries who receive care in each type. We're still developing this data and they're not in the materials that you have at the moment, but they will be in the version that will really be released for review by the end of the day -- hopefully by the end of the day.

We've also made some minor changes throughout the document in response to your discussion.

Lastly, I do want to remind everyone that Zach Gaumer also made significant contributions to the report.

Before we move on to the new substantive material, we went to briefly recap a couple of points about the hospice benefit that led us to where we find ourselves today. First, hospice provides an alternative form of care for beneficiaries who do not desire conventional

interventions at the end-of-life. In order to elect hospice, the beneficiary needs certification of likely death within six months. In electing hospice, beneficiaries forego curative treatment for their terminal condition but receive a wide range of services not covered by traditional Medicare with little cost-sharing.

Second, in addition to giving beneficiaries a choice about their end-of-life care, the hospice benefit was implemented with the expectation that hospice was less costly than conventional end-of-life treatment and would result in lower Medicare spending.

As we've discussed previously, Medicare's payment system contains an incentive for providers for long stays in hospice, rather than appropriate timing of admission. This incentive potentially undermines the statutory presumption that hospice would result in lower Medicare spending than conventional end-of-life care.

As indicated in your mailing materials, we see a number of parallel trends in hospice use. Length of stay is increasing but in a very uneven way. Average length of stay increased from 62 days in 2000 to 82 days in 2006. But at the 90th percentile of the distribution, the stays increased

from 144 days in 2000 to 212 days in 2005, an increase of almost 50 percent.

Stays at or below the median length of stay declined by a day during this time, so it is only the long hospice stays that are getting longer.

We demonstrated previously that there is a strong correlation between length of stay and profitability. Hospices with the longest stays on average have the highest Medicare margins. This may help explain why virtually all hospices newly participating in Medicare since 2000 have been for-profit enterprises.

Additionally, we believe that inadequate oversight may have contributed to these trends. CMS and its fiscal intermediaries have not had the resources to closely monitor trends or assess whether improper practices partly account for the patterns we've seen in the last several years.

Based on your prior direction and our subsequent analytic work, we developed draft recommendations in three areas which we presented in November. This work was further informed by input from individual hospices, hospice associations, and an expert panel we convened in October of last year.

First, we developed a direction for changing Medicare's hospice payment system, moving from a linear approach to an intensity adjusted approach, more consistent with hospices' efforts in caring for patients.

Second, we identified the need for more accountability in the hospice benefit and drafted a multi-part recommendation aimed at increasing accountability, which is detailed at length in your paper.

Lastly, we identified the need for more and better data with which Medicare could improve its management of the hospice benefit.

Today, first we will discuss the recommendation to change the payment system. As you will recall, Medicare's current payment system is generally linear. Medicare pays hospices a fixed amount for each day a patient is enrolled. The longer a patient is enrolled, the greater the hospice's Medicare revenues.

You'll recall, however, that hospices' costs follow a U-shaped curve. Hospices incur a higher cost associated with the increased level of effort at the admission of a patient to hospice and during the time surrounding the patient's death. The interim period is less

costly, reflecting the establishment of a routine of care.

Obviously, there are deviations from this pattern with respect any given patient that we might discuss, but in general this seems to be the general pattern.

This led us to recommend changing the hospice payment system in a way that more closely approximates hospices' costs during the course of an episode. Payments would be high in the early days of admission but would decline as the hospice stay got longer. Medicare would make an end of episode payment after the patient's death, reflecting the hospices' higher level of effort.

This structure would give hospices a greater incentive to screen potential patients to ensure they were admitted at the most appropriate time in the course of their terminal condition. It would also reinforce the notion that hospice is an end-of-life benefit rather than a long-term care benefit.

We had not yet completed our payment model in November but since then have developed two alternate sets of payment weights that follow the U-shaped curve. To keep this discussion clear, we will only talk through one example, portrayed on the screen, but you have a full

discussion of both in your paper. Together, they provide examples of how the impacts of the payment system change vary depending on the degree of the intensity adjustment. These weights now include the end of episode payment that would be made upon the patient's death, which we discussed but which we had not yet modeled when we presented the material in November.

The weights, as you see here, are higher in the early part of the episode. It's at this point, surrounding the patient's admission, that the hospice devotes a significant amount of effort. Activities include developing the plan of care, assessing medical and medication needs, introducing the patient and family members to the hospice team, and generally establishing a protocol of communications.

As the hospice episode continues, the patient's care settles into a routine with visits provided by the interdisciplinary team per the plan of care. Obviously, acute incidents can occur during this time, which may require disruptions from the standard routine home care.

Lastly, the weights increase at the end of the episode, associated with the higher level of effort by the

hospice surrounding the patient's death. In addition to palliative and patient care, these activities include pastoral and other counseling, and family counseling that can extend beyond the death of the patient.

There are a few other points that we went to emphasize in describing our payment system changes. First, our model deals with home care only and presumes that payments for inpatient care what continue as under the current system.

Second, payments are still made on a per diem basis but in contrast to the current system these payments would decrease as length of stay increases.

Third, payments under the new system would be budget neutral to payments under the old system in the first year.

Lastly, as shown graphically in the previous slide, the level of the end of episode payment made at the time of the patient's death would be at the same high rate as the payments made at the beginning of the episode.

The impacts of the new payment system relative to the current one would vary as a function of length of stay. Here we have shown the impacts by the share of a hospices'

caseload represented by patients whose stays exceed 180 days, broken into quintiles. We've shown the impacts of both the larger intensity adjustment that we showed on the chart a couple of slides ago, along with the smaller adjustment discussed in your paper.

Hospices with the lowest share of patients whose stays exceed 180 days would see their payments increase by 24 percent relative to the current system under the larger intensity adjustment. The effect on payments would decline along the length of stay continuum. Hospices with the highest shares of patients whose stays exceed 180 days would see their payments decline by almost 11 percent under the new system relative to what they are getting now. Payments under the weights reflecting the smaller intensity adjustment follow a similar pattern but with less pronounced changes.

The main point though -- and we will say this again before the end of the presentation -- is that the payment impacts vary as a function of length of stay.

Here you see the impacts of going to the new system as reflected in some of our standard provider categories. Geographically, urban hospices would see a

slight decrease in payments in either system, while payments to rural hospices would increase by between 2.2 and 2.8 percent, depending on the set of weights used.

Payments to provider-based hospices, which have the shortest average length of stay, would increase by almost 11 percent using the larger intensity adjustment and by almost 8 percent using the smaller adjustment.

Payments to for-profit and freestanding hospices would decline relative to the current system because these providers have longer stays on average than nonprofit and provider-based hospices. Payments to nonprofit hospices would increase by between 2.5 and 4.1 percent under the weights we have modeled here.

Within these categories, however, the new system's impact will vary considerably, again as a function of length of stay. For example, while half of for-profit hospices would see their payments reduced by more than 2 percent under the new system, 40 percent would see their payments increase by more than 2 percent. The reductions or increases within each category vary as a function of length of stay. So here, for-profit hospices with shorter stays will actually gain under the new system. Because their

lengths of stay tend to be lower, any more provider-based, nonprofit, and rural hospices would see their payments increase than would have their payments decline under the system we've modeled here.

As we stated in November, there are several benefits to the intensity adjusted payment approach. First, it reinforces hospice as an end-of-life benefit and incorporates incentives to ensure that hospice provides the optimal balance of benefits to Medicare beneficiaries and the program itself.

By incorporating higher payments at the beginning and end of the hospice episode, the revised system ensures that hospices have sufficient resources to deliver care at these particularly important junctures. It also better matches hospices' actual cost curve in the course of an episode and includes payment adjustments to make hospices more sensitive to the impacts of long stays.

We project that the revised system will reduce the number of hospices exceeding Medicare's payment cap. Under the two sets of weights projected here, the number of hospices exceeding the cap would decline by 26 percent under the smaller adjustment and by 45 percent under the larger

intensity adjustment.

Additionally, the new system provides higher reimbursement for patients with very short stays in hospice, which in the aggregate are unprofitable for hospices under the current system. As a result, this payment system revision may provide an incentive for hospices to take greater efforts to appropriately lengthen stays for what are currently very short stay patients.

It's worth emphasizing at this point that there is reasonably broad support for this recommendation across the industry in principle and as a general direction. There is some concern regarding the specific point estimates, what the payments should be during each part of the episode and how long each part should be. Some of you have expressed similar concerns.

On this note, what we are recommending is the direction that CMS should go in reforming the hospice payment system, not the specific point estimates. We've also modified the recommendation itself to give CMS additional time to collect and evaluate data to reform the payment system along the lines of what we are recommending.

Remember also the MedPAC will likely have ample

opportunity to provide additional analyses to help inform CMS's efforts and would, of course, have the opportunity to review the final system.

So now we'll move to the recommendation. Note that the recommendation has changed somewhat since you last saw it, clarifying some aspects of the new payment proposed system and adding a date certain for the new system to be implemented, as I just mentioned.

The recommendation reads: the Congress should direct the Secretary to change the Medicare payment system for hospice to: increase payments per day at the beginning of the episode and reduce payments per day as the length of the episode increases; include a payment system for the higher costs associated with patient death at the end of episode; implement the payment system changes in 2013 with a brief transitional period.

These payment system changes should be implemented in a budget neutral manner.

We now have a CBO score for this recommendation, which we didn't have in November. Because it would be implemented in a budget neutral manner, there are no impacts on spending in the first year. Over five years, providers'

behavioral changes in response to the incentives in the new system will result in relatively small savings.

We do not anticipate that the payment system change will adversely affect beneficiaries' access to hospice care. We expect that there will be fewer very long hospice stays as hospices pay closer attention to the timing of hospice admissions. At the same time it is possible that what are currently very short stays may become longer under the new system.

The effects of the payment system change on hospices will vary as a function of their share of stays over 180 days. To the extent that hospices with a large share of such patients are small and do not have a patient base that allows them to manage the risk of some patients incurring very long stays, they will likely have to increase their patient census or merge with other hospices in order to remain viable under the new system.

With that, I'll turn it over to Kim for the rest of the presentation.

DR. MARK MILLER: Can I just say one quick thing, just before we shift over to the accountability? I know you were just being really precise on the scoring. The

negligible savings over the five years, we are talking about $100 million on like a $10-plus billion base or something like that?

DR. MATHEWS: That is correct.

DR. MARK MILLER: We're talking about -- just in the interest of being clear about what CBO said -- but we're talking about dust in the end here.

MS. NEUMAN: We will now move on to our next recommendation. Last month we also presented information that led us to develop a two part draft recommendation on the need for greater accountability in the hospice benefit.

As we stated in November and earlier in this presentation, long hospice stays are getting longer while short stays remain largely unchanged. There is substantial variation across hospices in terms of the amount of long stay cases they have. The 20 percent of hospices with the most long stay cases have on average 34 percent of their hospice stays exceeding 180 days compared to an average of 14 percent among all other hospices.

We've also seen that there is a subset of hospices that rely very heavily on nursing home patients and these hospices tend to have longer stays and are more likely to be

for profit.

It is important to note there are inherent uncertainties in predicting life expectancy and it is natural that hospices will have some long stay patients. However, the increase in very long hospice stays and the variably across providers in the amount of long stay cases is a concern because information we have gathered suggests that it may be driven in part by financial considerations or other factors not related to the patient's condition.

As you'll recall, in October of last year we convened an expert panel of eight hospice medical directors and hospice administrators. Panelists came from both for-profit and not-for-profit hospices and from a wide range of geographic areas. A medical director from a Medicare claims processing contractor also participated. Discussions with the expert panel suggested two potential explanations for the trends we currently observe in long stays.

First, some hospices could be responding to the profit incentives for long stays in the current payment system. Such hospices may choose to interpret Medicare coverage guidelines in such a way as to liberally admit patients of questionable eligibility, especially patients

likely to have long stays. The correlation between length of stay and profitability, the entry almost exclusively of for-profit hospices, and the specialization of some hospices on nursing home patients reinforces this hypothesis.

Furthermore, several expert panel members provided examples of questionable enrollment practices among some providers in their communities such as, at the extreme, some hospices reportedly prohibiting physicians from visiting patients for recertification purposes, never discharging patients for improved prognosis, enrolling patients who had been turned away by other hospices, disregarding the Medicare eligibility guidelines, aggressively marketing to individuals likely to have long stays as such as nursing home patients, or marketing hospice without mentioning the terminal illness criteria.

Second, some members of the expert panel believe that some hospice staff, both the medical directors, physicians and clinical staff, may be insufficiently trained in palliative medicine to adequately apply CMS's coverage guidelines to specific patient circumstances. In this case, insufficient engagement of the hospice medical director may also be a contributing factor.

Which brings us to draft recommendation 2(a), which describes additional controls that should be put in place to help ensure that Medicare's policies encourage hospices to admit patients at a point in their terminal disease trajectory that provides the most benefit for the patient. The measures in this recommendation are targeted to increase accountability and oversight most on hospices with the longest stays.

This is generally the same recommendation you saw in November with the exception of the third bullet. Previously it focused on long stays at hospices with an average length of stay of greater than 120 days. We've changed it to direct the attention on hospices with a large share of patients whose stays exceed 180 days. This change better focuses attention on those hospices that have a large share of patients whose stays exceed the six-month presumptive eligibility period.

The draft recommendation now reads: the Congress should direct the Secretary to: require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th day recertification and each subsequent recertification, and

attest that such visits took place; require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis; and require that all stays in excess of 180 days be reviewed by the applicable medical director of the Medicare claims processing contractor for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.

The supporting narrative also indicates that the Congress should provide CMS with the resources necessary to enforce existing policies applicable to the hospice benefit and any new policies adopted on the basis of the recommendations herein.

Just one other note on this recommendation. Just to be clear with regard to the third bullet, as written it would only apply to the fiscal intermediaries and the Medicare administrative contractors. So if you wanted other parts of CMS to be doing the reviews of these claims, we would need more generic language there.

Again, we now have a CBO score for this recommendation. CBO estimates that it will have a very small effect on Medicare hospice spending.

There are a couple of potential effects on beneficiaries. First, beneficiaries who are currently receiving hospice care even though their symptoms do not meet the applicable guidelines are likely to see the timing of their admission to hospice change and be admitted to hospice later in the progression of their disease. Second, the greater physician engagement in the beneficiaries' hospice care could result in great quality of care.

The effects on hospices would vary again, as with our payment system recommendation, as a function of their share of patients with stays over 180 days. The additional medical review of claims would only affect providers with at least 40 percent or more of their cases exceeding 180 days. Also, providers with the most long stay patients would incur the greatest costs in providing physician visits as a part of recertifications for patients with stays exceeding 180 days.

We anticipate there would be a modest impact on all hospice providers of including a narrative with each certification and recertification.

The second part of our accountability recommendation dealt with the need for OIG studies of the

intersection of Medicare's hospice benefit with nursing homes and other long-term care facilities. The draft recommendation has also changed slightly from the last time you saw it, with the addition of assisted living facilities in response to Bill's and Nancy's comments and the additional bullet on the appropriateness of enrollment practices among providers with unusual utilization patterns in response to Mitra's comments concerning program abuse.

Also, the final bullet has been broadened to include other admissions practices in addition to marketing materials and to examine their correlation with length of stay.

The draft recommendation now reads: the Secretary should direct the OIG to investigate the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may reflect a conflict of interest and influence admission to hospice. Differences in patterns of nursing home referrals to hospice, the appropriateness of enrollment practices for hospices with unusual utilization patterns -- for example, high frequencies of very long stays, very short stays, or enrollment of patients

discharged from other hospices -- and the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and efficiencies in marketing or admissions practices.

The implications are the same as last time, with no impacts on Medicare spending. The OIG would be required to spend administrative resources on conducting these studies. The recommendation would have no immediate impacts on beneficiaries or providers.

We will now move on to our third draft recommendation, with deals with additional data needs. In November, we discussed the fact that the information currently collected via claims and cost reports is insufficient to fully understand the changes in hospice utilization that have occurred in the last several years. We presented two recommendations that outlined additional information that should be collected. For example, we indicated that claims should include information on the duration of visits provided and that cost reports should include both Medicare and non-Medicare revenue.

As a result of discussions with the Chairman since the November meeting, we have combined the prior separate

cost report and claims data recommendations into a single, more general, recommendation on the need for more data. The supporting narrative remains much as it was in November and outlines specific information CMS should collect via each of these two mechanisms.

The recommendation now reads: the Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

The implications of the recommendation are unchanged from last time. There are no direct spending implications but CMS and its intermediaries would be required to expend resources developing new cost reports, developing new claims fields, and developing corresponding provider education materials.

There would be no implications for Medicare beneficiaries, although the data could result in long-term refinements to the payment system that can help ensure equitable access for beneficiaries with all terminal conditions.

Providers would incur some additional costs as a result of this recommendation. These would include the costs of claims and cost report software, as well as training for staff on the new requirements.

To summarize, recent trends in hospice use suggest the need for reform of the benefit on the number of fronts, including payment system changes, the need for greater accountability, and the need for additional data to manage the benefit.

With that, we will conclude our presentation and we will be happy to answer any questions you may have.

MR. HACKBARTH: Nice job. In fact, nice job over a period of months on this project.

I had a couple of clarifying questions. In fact, I know Jack has one that is the same. Do you want to go ahead, Jack?

MR. EBELER: Jim, if you could go to the sixth slide, I just want to clarify for purposes of helping us understand the direction of these changes you've modeled these different percent weights and your subsequent analyses sort of show the direction of change with these weights and other weights. But as I understand, the recommendation

itself is not to use these weights but instead to direct the Secretary to come up with a stronger analysis to come up with the appropriate intensity weights. So these are examples, not recommendations, is that correct?

DR. MATHEWS: That is correct.

MR. EBELER: Okay. Thank you.

MR. HACKBARTH: Just to follow up on that same point, the policy goal, or one of the policy goals, is to change the payment system so that there is a reason to really focus on the admission decision, who is admitted to hospice, and make sure that they are appropriate in keeping with the purpose of the benefit. You change the weights to help achieve that goal.

Now, it seems to me that you only achieve that goal if for the long stays the payment level is below the marginal cost of delivering the care. So long as the payment is higher than the marginal cost, there's a reason to keep on delivering additional units of service, days of care in this case, is that right?

So what we're asking the Secretary to figure out is collect data that would allow them to make a reasonably good assessment of what that marginal cost is and that's an

important factor in the intensity weight for the long days, right? And so the data collection has to be done with an eye towards trying to approximate that figure, question mark?

DR. MARK MILLER: That's right, in concept. That's all correct. But I also think we should be -- and I need real engagement here from you two -- we also have to be careful that we're not overselling the precision that we're going to be having and able to do this. I think part of the reason the accountability things, or recommendations are in there, in particular looking at stays from hospices that consistently have long stays, are in part to also try and back in behind this, because the ability to extract data that says, this is precisely the right shape for this curve and here is the right marginal cost, I don't know that that's actually going to exist with that degree of precision.

The second comment on this that I would take you guys back to in your November discussion is there was also some discussion of, well, notionally you want a normative feel to this, that even if the data itself has a certain pattern, there may be an attempt with this payment system to

kind of shape the way care is provided during the episode, as well. So there's some --

MR. HACKBARTH: What I'm trying to get at is that I think I understand, at least in a broad sense, why it will be difficult to find that marginal cost figure with precision. But if you fail not to get the long stay payments low enough so that they're below that marginal cost, you may well not achieve in your policy goal, which is to affect the admission decision.

DR. REISCHAUER: Don't you want it below rather than equal to the marginal cost?

MR. HACKBARTH: Well, I'm out of my element here, as you well know, being a lawyer. But basically, what you're trying to do is get people to say providing additional units is not in my organizational interest. I want to think very carefully about that initial admission decision. So long as the payment is above the marginal cost, I'm not sure why they would think differently about the admission decision.

Now I'll shut up and let economists talk.

DR. SCANLON: Well, I mean, my sense was it's partly related to precision, but it's also an issue of sort

of how aggressive we are here, because I'm not sure -- whether it's marginal costs or whether it is something between marginal and average costs that we really should be aiming at. I would worry that sort of in the seventh-plus month, that if you get the rate too low, I don't want stinting in that period, either. And so the situation now is horrible, I mean, in terms of the difference between the potential cost of care and the payment. You want to improve that, but I'm not sure you can get it to the point where it's -- you're exactly at the right level. And so you've got to balance it between this issue of don't encourage overutilization, but also sort of don't encourage stinting. Because again, we're sort of in a situation where we don't know what services are being provided.

DR. CROSSON: I think this question is a little bit derivative of the discussion that we just had and it requires referral to the figure two on page ten in the text, which was not in the presentation.

It has to do with, again, the topic of the relationship of the shape of the intensity adjustment to the impact on categories. This is sort of to set up a discussion perhaps later about whether or not this should be

budget neutral or not, or more aggressive than that.

So if you look at figure two on page ten, it shows the relationship between profitability and length of stay. If you take, for example, the 2006 numbers, it looks like -- and I'm going to use quintiles because that's what is then used in figure eight in the presentation -- that the average margin -- and correct me here if I've made a mistake somewhere -- the average margin is about minus 3 percent. And for the quintile at the top, it's about 20 percent.

So I'm assuming these quintiles are roughly comparable to the quintiles that are then displayed in figure eight, although I can't tell because I'm not sure what the horizontal axis is in figure two. But if they're roughly comparable, it would suggest that if this particular intensity adjustment were applied, the net result -- and again, tell me if I'm wrong here -- would be to increase the profitability of the lower quintile to somewhere around 20 percent and decrease the profitability of the highest quintile from about 20 percent to about 10 percent, which sounds a bit similar to what Glenn was suggesting in terms of whether this particular model fits with the goal. So I just wanted to see if that, in fact, is the case.

DR. MATHEWS: We have not actually connected these two graphics in the way that you're anticipating. Listening to you ask the question in the way that you have, I think there is some intuitive logic to the direction that you've laid out. The metrics for length of stay are slightly different between these two charts. On the one on the screen, we are measuring length of stay for this purpose as share of a hospice's patients who exceed 180 days. In figure two -- and you are correct, the legend is missing here -- the metric is the hospice average length of stay. So they are slightly different, but conceptually still get to the same place.

I would not want to definitively answer your question on the spot because I think there might be some patient weighting things that we would need to take into account, especially with respect to figure two, to make it exactly comparable to the chart here.

But yes, in general, this payment system change would increase the profitability of what are currently low length of stay hospices and decrease the profitability of hospices with very long lengths of stay.

MR. HACKBARTH: The trick here, it seems to me, is

that we're talking about a payment system that still is -- it's not an episode-based payment system. It's still paying for additional units of service, additional days. Yet we have a policy goal which is sort of episode focused. We want to reduce the number of very long stays, but using a payment system that still pays more for each day.

Those two things, there's some tension between the payment method and the policy goal. And we're trying to resolve the conflict through pricing of the individual units and that is, I think, complex.

DR. CHERNEW: Do you mean episode in that sentence, like episode, hospice episode, or did you mean episode in that sentence like episode, end-of-life episode?

MR. HACKBARTH: I don't know. I was thinking hospice episode, but I am probably making a mistake by saying that. Why do you ask?

DR. CHERNEW: I was thinking end-of-life episode, but it sounded from your sentence like you were thinking hospice episode, and that --

MR. HACKBARTH: Yes.

DR. SCANLON: Kim, on recommendation two, you raised the issue for the third bullet about whether we would

want to modify it in terms of thinking of other parts of CMS or HHS. I guess the one that came to mind for me is the program integrity contractors. Was that where you were going, and do you think it's appropriate to expand it from both claims processing contractors to the program integrity contractors, as well?

MS. NEUMAN: The program integrity contractors, this is something that could be considered and they do do this type of review. So that is a potential option. There are other groups, as well, that sometimes do reviews, such as the RACs or the QIOs. Program integrity seems a natural, though, in the scheme of the other entities that are out there.

DR. CASTELLANOS: I think my questions are in part two, so I will wait.

DR. STUART: I'm fully in accord with the direction of these recommendations and I think you've done a great job in terms of laying out the issues for us.

I think we are all keenly aware of some of the issues at the margin in terms of how this is going to affect provider behavior. But one of the things that's not written here is that if we recommend that the provider payment

system be changed in 2013 and beyond, it means that we are still stuck with this thing for the next three years.

And so my question for the record is how are payment updates made currently for hospice, and then I have one follow-on question.

DR. MATHEWS: The hospice payments are updated annually by the inpatient hospital market basket.

DR. STUART: Okay. All right. And then the second --

DR. MARK MILLER: [off microphone] They are automatic.

DR. MATHEWS: That's correct.

DR. STUART: Right, because we have not made a recommendation about that. But implicitly, we're saying, okay, well, we're going to continue -- we recommend by not saying anything that we continue with this current system until the new system comes into place.

And then the second piece, by virtue of the fact that we're going to be maintaining this system for three years, even if the recommendation one is recommended, some of Kim's points certainly strongly suggest that there's some bad behavior out there. I agree with Jay in the sense that

if you've got bad behavior out there and we're struck with the current system for three years, that bad behavior that increases current spending is going to be incorporated in the payment base. So that question about budget neutrality for something that starts in the future is a concern, I guess.

DR. MARK MILLER: The one thing I would say about that -- and again, this is mostly a resource and timing issue. Next fall, and I realize your question could be, but why not now? We've been investing in trying to understand the area. Next fall, we anticipated once now everybody has a better understanding of hospice, we've made some recommendations to fix the underlying system, we can move to regular order of business on hospice and looking at updates. So I wouldn't assume that you're living with -- well, I mean, living with the underlying system for the next few years, but it doesn't necessarily mean that we are immediately saying all updates for the next three years are okay.

DR. MATHEWS: If I could make one more observation on that point, recommendation two, both A and B, are separable from the payment system recommendation and

arguably these could be implemented on a much quicker track than a payment system change.

MR. HACKBARTH: I assume the reason for the longer time period for the payment system reform is that we hope to use the additional data collection to inform the setting of the actual weights, is that correct?

DR. MATHEWS: That is correct, and waiting until 2013 does give CMS a chance to get past the first year of data collection and start using data from years two and three, evaluate that, and promulgate a proposed rule.

DR. KANE: I have a second tier comment, but I guess my only first query question is what is an -- and I think it relates to what Mike was saying -- what do we mean by episode, because the benefit periods are 90-day increments. But what do we mean by -- I think we need a definition of episode in there. I think you mean from the minute you're admitted until death, but I don't think we have a common definition of episode yet.

Especially if you're trying to get past seven months and have that be -- when does month one begin and when does an episode end? What if they been discharged and reentered? Is it cumulative, because his grandmother went

in, what, two times and she's still living.

DR. MATHEWS: For purposes of this discussion, we been defining the episode loosely as the point of admission to hospice to the point that the patient is discharged or dies. If this system were to be implemented, CMS would have to deal with issues related to discharge live and subsequent readmission and how the payment would play out in those scenarios. Neither in this situation have we considered pre-hospice care as part of the end-of-life episodes. We are just dealing with what happens under the hospice benefit.

DR. CHERNEW: You mentioned the CBO scoring, and it's not surprising that it's a small effect because the recommendation says it should be implemented in a budget-neutral way. So it's pretty budget neutral.

My question was, did they make assumptions -- what assumptions did they make when they talked about behavioral changes that made it not exactly budget neutral? Was involved in changes in the use of the hospital or the nursing home or things like that, or was it just changes in length of stay?

And I have one more clarifying question about the

CBO calculations.

DR. MATHEWS: Yes. We've had very brief conversations with CBO on the rationale and one of the offsets that result that would -- one of the behavioral responses, or one of the factors that offset savings that would accrue under this proposal is the fact that delayed admission to hospice would presume continued use of other Medicare Part A and Part B services.

DR. CHERNEW: The last question I had about their scoring was did they take into account their baseline of the increased trend in length of stay, which is what I think would happen if we kept the current system, or did they not? In other words, this would reduce this trend we have had for greater length of stay, and so the savings relative to their baseline depend on if you think we keep the current system, that's going to keep going up. So it's budget neutral where we are now, but it's a big savings compared to where we would have otherwise been.

DR. MATHEWS: I do not know. We did not specifically discuss that point, but we can loop back.

DR. MARK MILLER: Actually, since they are working off of their current baseline, you know, they set a

baseline, they look at current trends, I think it's pretty safe to assume that they assumed some increase in lengths of stay, observing current data and projecting it forward. Precisely how much, we'd have to go back and ask.

DR. CHERNEW: But when we mean budget neutral, that's not what we mean. We don't mean implemented in a budget-neutral way that mimics those length of stay increases over time.

DR. MARK MILLER: Absolutely.

DR. CHERNEW: We mean budget neutral relative to where we are now. So a budget neutral thing relative to where we are now should be a big savings relative to their baseline, I would think. That's what I'm trying to clarify.

DR. MARK MILLER: There's a couple of things going on here. First of all, some of this conversation was also with Peter's question yesterday about the ASCs. When you go to a different payment system, you make an assumption about budget neutrality at the point where you are. We are making no attempt to pull money out as we reset the payment amounts. That's one budget neutrality concept. And so just to be clear, there's not an attempt to move money out at the point that you restructure the system.

The second point that we're making over the first year and the five-year point -- and this is really CBO making this point -- is that, well, on net, what happens to spending over that period? What they're saying is that there is a negligible -- which I can't say but apparently they can -- difference in the baseline.

I think part of what's going on is hospice expenditures will continue at some rate, and to the extent that a beneficiary doesn't go into hospice at the points that they currently are, some of that spending will be incurred on the acute care side. Is that --

DR. CHERNEW: I understand that that's possible. It is surprising to me, because I was under the impression that the growth in hospice spending was in part driven by this incentive to long length of stay. So I was under the impression that the trend in baseline was relatively high because of increasing length of stay. And I was under the impression that this recommendation, which I support, changes that incentive. So whatever --

DR. MARK MILLER: It's two things, though, Mike. People have been using the benefit a lot more and length of stay has been increasing.

DR. CHERNEW: It could work out that way. I just, in the things that I thought were important magnitude-wise in my mind, I was focusing on one relative to the other. So it might be that's true. I was trying to figure out if CBO -- how they were scoring the recommendation budget neutrality.

DR. MARK MILLER: And I'm giving you our best sense.

DR. CHERNEW: So I think I understand now.

DR. MARK MILLER: And on the very point about what's driving the expenditures of the length of stay versus the number of people, we kind of don't want to discourage the number of people.

DR. CHERNEW: [off microphone] I agree.

DR. REISCHAUER: Your definition of budget neutrality is based on a single year's spending, not on the next five years' spending.

DR. MARK MILLER: Absolutely, and so let me just restate this, and I'll do this very briefly because I know we're running out of time. It could very well have been, and in fact, we didn't know what to anticipate, that you build a budget-neutral system at year one and the behavioral

changes result in significantly less spending over five years, and not because the system tried to take money out but because of behavioral changes. What they are saying is that you're getting it in other places.

DR. CHERNEW: I'm going to forego my round two question and say, but the behavioral changes might not be behavioral changes relative to what we see now. They could be the absence of behavioral changes that we otherwise would have seen that are incorporated in the CBO baseline.

DR. REISCHAUER: They should be both.

MR. HACKBARTH: Mark, I'm a little concerned that the impression that we're leaving for the audience is that CBO has done a detailed budget estimate of this, and my understanding is that they have not. First of all, there's nothing for them to estimate. There's not a specific policy proposal. So in terms of actual weights and how they might affect behavior, and so would you just address what CBO has done here?

DR. MARK MILLER: As best as I can. Generally, what happens in our process to do these kinds of spending impacts is it's kind of a -- I wouldn't call it a full, and to your point, a full bore cost estimate that CBO does like

when they get a piece of legislation. Often what happens is we go through -- and we didn't do this so much here, but on the updates we will do a pass on the savings ourselves and then say to CBO, we think this generally falls in a set of buckets. Do you agree? And they say yes or no, and then we present the buckets.

Here, I don't know that we took a pass at this. We said our intention is budget neutral, told them the structure of the policy and gave it to them. They came back and said, this is what we think.

I don't know if there is any more precision you guys can bring to it.

DR. REISCHAUER: But the amount of behavioral change you are going to get is going to depend on the extent to which we have the intensity adjustment, you know, how deep the curve is. So there's no way for them to do it without very specific numbers. And if it's sort of a shallow curve, I can believe that there will be sort of offsetting effects and there won't be a whole lot. But otherwise, I think this chapter is basically an argument for why there should be rather substantial savings in hospice, and then you have to go to the literature on the extent to

which hospice for low-intensity kinds of people ends up saving or costing Medicare overall resources.

MR. HACKBARTH: It sort of sounds to me, Mark, like in a way, we gave the CBO the answer to the question when we asked the question. We said, this is a budget neutral change in payment policy, and they're saying, well, if it's budget neutral, then by definition there's not a big budget impact. And they really didn't have the wherewithal to look at complex behavioral responses to a new payment system.

DR. MARK MILLER: I'm trying to make eye contact with a couple of people here, and my sense is they did not proceed in that way and just say, okay, because you said, it is. They actually did look at what the potential behavioral effects of the policy was, is that right, Shinobu? Right. So it wasn't just a straight out, you said so, so we're taking it. We gave them some data. They did look at current baselines and they made some assumptions. Exactly what's behind that, I think is what we are not able to articulate.

MR. BUTLER: I understand, though, the most important thing is that you have -- are we going to do the

U-shape or not and how shallow or deep should it be is the heart of what we're advancing.

So my question more out of curiosity is that often, we are addressing issues in a somewhat similar fashion that Congress and CMS is doing on certain benefits. Is this one where we are out ahead of what is being considered by others? Or is something like this being considered already by CMS or Congress? Are we kind of like leading the way in this?

DR. MARK MILLER: I only heard the end of the question, but I think we are leading the way on this. However, since our discussions have occurred, we have been talking to CMS throughout this and CMS has said that they are very interested in these ideas. Kim? Is that correct?

MS. NEUMAN: Yes.

MR. BUTLER: I have one other quick follow-up question. We've talked a lot about financial disclosure in the past and make recommendations about collecting additional information and so forth. In this case, we are very specific about having the Secretary direct the OIG to do the leg work, which I understand is one way to do it. Is there any other flexibility in terms of who or how you would

address the conflict of interest issues, short of or different from the OIG?

DR. MARK MILLER: One thing on that point, and there was actual a little discussion between Bill and I this morning, is I anticipate that we will continue ourselves to look at the nursing home interaction, which is one of the conflict of interest issues, and that as we move forward and discuss this in the fall of next year, that in addition to whatever else we may want to say about hospice in general, we may have something more to say about that.

We ran through the data analysis which is reported in the chapter. It gets fairly complex about how to design a policy to deal with that, and so we just didn't feel like we were ready to go with a policy. But I would see us continuing to pay attention to this, at least.

MR. BUTLER: I just mention that because OIG at somebody's doorstep sets a different kind of tone in terms of collaboratively trying to figure out what's going on than maybe some other approaches.

MR. GEORGE MILLER: On draft recommendation two, I've got a clarifying question. It says they require that a hospice physician or advanced practice nurse. Now, is that

a palliative care physician boarded? Or is it an employee of a hospice program? And the same thing for nurse practitioner. Are you being specific on what the degree and the capability of that physician or any physician working for the hospice?

DR. MATHEWS: Here, we are defining this physician as the hospice medical director who has the responsibility for recertifying patients for hospice.

MR. GEORGE MILLER: The second part of that, as we try to deal with length of stay, would it make more sense or would it be something to consider moving the -- you say prior to the eligibility of the 180th day. Would it make sense to try to play that at the 90th day as being very prescriptive? And then maybe in addition to the 180th day, as a clarifying question?

DR. MATHEWS: Obviously, that's feasible, and when we've had discussions with some segments of the industry, some members have suggested that we could be indeed be even more --

MR. GEORGE MILLER: Prescriptive.

DR. MATHEWS: Yes, further up on the episode than we are here. So we are being very conservative in this

recommendation.

MR. GEORGE MILLER: But wouldn't we have a different impact if it was the 90th day, is my point I'm trying to address.

DR. MATHEWS: Yes.

MR. GEORGE MILLER: That would be more prescriptive?

DR. MATHEWS: That's correct.

MS. NEUMAN: And just to add to that, there are costs and benefits of shifting that time line. A lot more patients would be affected by the 90th day recertification than 180 days. So if you're trying to target resources, 180-day targets you toward the patients who are moving beyond the presumptive eligibility period potentially.

MR. GEORGE MILLER: But I just want to reflect just -- I agree with Bruce, and I made the statement about home care. I'll make it here. Apparently, there are very bad actors and I'm struck by the relationship, and Peter mentioned it, with the nursing homes and the for-profit entities. I'm having problems with that and trying to reconcile all that in my mind. If we're going to do additional work, I'll just stop talking now and wait until

we get that additional work, but I'm concerned.

DR. MARK MILLER: This is probably obvious, but just to make sure that the public understands, the intent here was we think that there is a tail of a distribution here, in terms of both actors and -- in terms of actors who may be driving a lot of this. And so rather than have the accountability be very broad-based and in everybody's business, we are trying to target this to the tail of the distribution.

If it turns out we're wrong and we've been too conservative, perhaps we can revisit it. But our opening intent here was to not go after everything, just to try and get that tail.

MS. HANSEN: Thank you. Some of my other clarifying questions have been answered, but there's just one, because the magnitude and the difference of the three different recommendations are quite different relative to changing the payment system and then some accountability and then further study.

The question I still have on recommendation number two and the set of bullets underneath it is the necessity to put it in this format, one whereby there is no statutory

authority right now for CMS to require some of this documentation, because the documentation issues seem in some ways to be so straightforward that it would be a regulatory built-in requirement as a provider to not have a documentation of eligibility or recert and having a narrative. I mean, everything else is so basic in terms of plain accountability 101.

So I'm just curious that it just hits at this magnitude of being in a recommendation here versus something that CMS could require you to do.

MS. NEUMAN: We asked CMS whether they had the statutory authority to carry out these three tasks under recommendation 2(a). With an initial look at it, they felt that they did have that authority, so the way the recommendation is worded is the Congress should direct the Secretary. It leaves that sort of open. It's not saying that the Congress needs to enact the authority to be able to do this, but to direct CMS to carry out these steps which are within their jurisdiction.

And then the supporting narrative just urges the Congress to give CMS the resources to do some of these things, such as reviewing the stays in excess of 180 days,

because those kinds of things are very resource intensive, and as we have discussed previously, their resources are quite limited. So that was the motivation.

MS. HANSEN: But theoretically, bullets one and two are just kind of things that could be done, because I do understand the third bullet would require more resources.

MS. NEUMAN: It's our understanding that bullets one and two could be done under their current authority.

DR. DEAN: I'm not very familiar with the benefit in general, and I was curious, when a patient enters hospice, is there a requirement on the provider for a minimum level of service, or what does the provider commit to when the patient is enrolled?

And secondly, what specifically does the recertification require at the 180-day level? What's the wording or what specifically does the certifier have to verify or have to committed to?

MS. NEUMAN: I'll address the second part first. You're asking about current policy regarding what recertifications need to entail. So both the certifications and the recertification need to include basically a statement that the patient's prognosis is terminal given the

normal -- if the disease took its normal course. The physician would need to sign that piece of paper. There is no rationale as to why they are terminal or anything of that sort that's in the certification itself.

Then what needs to be in the medical record is information that if someone reviewed the record, they would come to the same conclusion, that the patient is terminal. But no sort of summary or anything of that sort, sort of looking at this record, this is why we think the patient's life expectancy is six months or less. That is currently the state of the rules.

What this recommendation would do, it would say to the physicians that they would need to, in the certification, put a brief statement as to why they think the patient's prognosis is terminal and that that would focus more attention on the eligibility criteria and physicians knowing that it's their responsibility to make sure that the patients actually meet it.

DR. DEAN: So at the 180-day time point, is the standard still that the patient is likely to die within another six months?

MS. NEUMAN: Yes.

DR. DEAN: So it basically extends the period another six months, and that can be done time and time again?

MS. NEUMAN: Exactly. So at every recertification, the criteria is, is the life expectancy six months or less at that point in time.

DR. MARK MILLER: [off microphone] And the certification is for 90 days?

MS. NEUMAN: The first two are 60, and then after that, they're all 90. Sorry. The first two are 90 and then after that 60. I apologize.

DR. MARK MILLER: So the decision is, or the clinical point is this patient is likely to die within six months, and the recertification is for 90, then 60 days.

MS. NEUMAN: Yes. Just to restate, because I have been unclear, so you have your initial certification. Then there's another recertification at 90 days. Then there's another recertification at 180 days. And then there's a recertification every 60 days after. That's the policy.

DR. DEAN: The other part of the question was what is the requirement when the patient enters? Is there some specific minimum level of service that is required, or is it

purely up to the provider?

DR. MATHEWS: There are a core set of palliative care services that the hospice has to be able to provide. So when the patient is admitted, the patient is assessed. An interdisciplinary team lays out a plan of care specific to that patient and identifies which of these core services the patient needs -- physician care, nursing care, counseling, social worker-type services, that sort of thing. But the regulation is not prescriptive as to any minimum level of service in any of those categories that needs to be provided to a given patient.

MR. HACKBARTH: Time for round two. Let me kick that off with a question and comment, because I want people to have a chance to react to it. Could you put up draft recommendation 2(a)? Kim, I think I detected in something you said that we may want to think about the level of specificity in bullet three, where we make a pretty specific suggestion that the medical director of the Medicare claims processing contractor should do some work. I thought I heard you say, well, maybe that should be broader language and that, in fact, CMS might prefer more latitude on that.

MS. NEUMAN: Yes. You could consider having not

just CMS's contractors, but also CMS potentially have that ability. So there could be more generic language considered there if you'd like.

DR. MARK MILLER: For example, could it read applicable Medicare contractor, or would you keep the medical director language in there, or would it just go from applicable to contractor?

Since you are conferring, I'm going to say from applicable to Medicare contractor, it would just say, applicable Medicare contractor.

DR. MATHEWS: The only reason we were hesitating there is that, given that what we are asking them to do is review the medical documentation related to determination of eligibility, you might want to have a clinician be responsible for this type of work rather than someone who is looking to make sure all the boxes are filled in.

DR. MARK MILLER: For purposes of the recommendation, if we said applicable Medicare contractor and talked about that in the text?

MR. EBELER: [off microphone] [inaudible]

DR. MARK MILLER: That's not a bad thought.

MR. HACKBARTH: If we have gotten a signal from

CMS that they would like a little broader language, I would like to accommodate them. This is the theme. Why don't you think about what that language should be while we go ahead with other round two questions and comments.

DR. SCANLON: I was going to make a comment about this in round two, which is that I was going to suggest that we just change it that the review is by CMS, and it could be a medical review, so that we make sure it is clinical. But there is this issue in legislation where something is designated to somebody and then that responsibility gets delegated. And I think it is fine here to delegate it to contractors. I see no reason, though -- not that this would tie CMS' hands, but that CMS could be doing some of these reviews themselves. And so just we want them done; kind of how they get done is the other issue.

DR. CROSSON: I'd like to congratulate both of you for this work. I think based on discussions we have heard in the past, the Commission is leading in this area, and I think that is something we should be proud of.

I have support for all three recommendations. I would like to bring up an ambivalence about part of recommendation number one, and that has to do with the

budget-neutral manner. Now, I think I can understand, given the moving parts here in all of these recommendations and the complexity of this, why one might want to start at a budget-neutral manner.

On the other hand, if you look at the relative profitability here -- and, again, I am referring to Figure 2 in the text on page 10, which is the margins, most recent margins across the industry -- they look relatively high compared with some other segments that we have dealt with. So the middle of the distribution here is in the range of 8 to 10 percent with the range going from minus 3 up to perhaps 20 percent.

So just in terms of how we think about increases, or not, in different categories of payment, what is the rationale for choosing budget neutral here? And should we reconsider that and actually, in view of what the CBO has scored here, think about something different?

MR. HACKBARTH: I've seen a number of heads nodding on that issue. Could I just get a show of hands of people who share that same concern about whether we want to use -- okay.

DR. REISCHAUER: Let me say something about that.

Unless we have evidence that we are underpaying the good actors, there is no reason to change the system in a way that takes money from the bad actors and boosts the good actors, I think which is what Jay's point is. You know, so if that is the case and we think that, you know, appropriately behaving hospices are getting margins that are about average, then we should take the money away.

DR. MARK MILLER: A couple of reactions to this. One, I wouldn't put a lot of weight on the CBO analysis, again, because given sort of the level of effort -- with no commentary intended there. It just wasn't an official piece of legislation, that type of thing. I think what drove us in this direction, with you guys doing close air support, is, one, remember also what each of you have expressed in every one of these conversations: Are we sure we are not doing any damage here? So I think that is part of what drove us in that direction. If I recall from back in November or whenever we looked at that, there is a pretty wide distribution in profitability here, maybe you could --

DR. MATHEWS: That is correct. And I would also again go back to my earlier caveat about Figure 2. This is not volume weighted, and so if you were to weight the

hospices by the volume of patients, there would be many more patients who would be seen by hospices at the lower end of the profitability distribution than there are in the higher end.

The second thing I would put on the table for you to keep in mind as you deliberate this point is that the relationship between length of stay and profitability that we have shown in Figure 2 and the impacts that we have shown here presume current law as it was prior to CMS' phase-out of a budget neutrality adjustment factor that began -- or it will begin this year, which will reduce payments over the course of a three-year period to a level 4 percent lower than they currently are.

So, again, just something to keep in mind that, in addition to the points Mark made, there is a certain amount of dynamism going on with respect to current levels of payments.

MR. HACKBARTH: In addition to that, as was pointed out earlier, we are talking about a system that we are saying goes into effect in 2013, and there will be opportunities between now and then to look at update recommendations if we are so inclined.

Just one other thought, Jack. There are a number of people in the room who have lots of experience with development and implementation of new payment systems. My sort of take on that over the last couple decades is that there is sort of a tradition that you do it budget neutral initially, and then you take the steps to alter the rates to squeeze out excess profit, and you separate those two steps. You do the redistribution in one step, and then you try to wring out the excess in the second and third steps.

You know, I think that there is --

DR. REISCHAUER: [off microphone] [inaudible]

MR. HACKBARTH: Right. I think that there is some wisdom in trying to separate new payment system development and redistribution of your payments from trying to wring out excess profit. So that is just a thought, and I would like people's reactions as we go around.

DR. CASTELLANOS: First of all, Jim and Kim, I think you guys did a great job. Jim, you really have brought us along over the past several months on the hospice issues, and I really appreciate your help and being able to talk to you about this.

As you know, I am a practicing physician. I was

just sitting here thinking. I go to a lot of meetings; most of them are medical meetings. And if this subject was brought up in a medical community with hospice people, physicians, nurses, the tenor would be entirely different. I think we can't forget to focus that we're dealing with people and we're dealing with people's lives and we're dealing with families. And there are some bad actors out there, but the majority of what is being done by hospice is excellent care. And we don't want to throw that baby out with the bath water. We really need to remember that they provide a tremendous service to this community, or to our community and society.

I have a couple of questions. One is I think we are focusing in on the long term, and by doing that we may be doing some harm with the short term, especially delaying people getting into hospice. And what you are going to do is keep these people in the acute phase of reimbursement with Medicare. And I think, Mark, you mentioned that.

We have all seen the tremendous costs in the last six months of life. We had the discussion where the Mayo Clinic compared to UCLA in increased costs, and I just have some concern that we are focusing on the long-term bad

actors, but there are some short-term bad actors, too. These patients aren't getting in. They are staying in the acute side, and these expenses are extremely high. So we need to focus in.

First of all, I agree with all the recommendations. Can we go to recommendation number two? You know, what we are doing is making medical decisions for financial reasons, but I think what we also need to do is make sure we -- and we haven't really stressed it with the hospice physician and the referring physician. We need to stress the appropriateness -- and by that I mean the appropriate referral to hospice when the patient elects this benefit. We really may even think about an education process, because I think that is where we need to do it. I think what we need to really do is focus in to make sure what is happening is being done appropriately on a medical decision, not just a financial decision.

Kim, the other issue I have is -- you talked about a little the fiscal intermediaries, the medical contractors, and I can remember, Jim, we had several discussions on this. I think there were four or five medical contractors, and it seemed that one of them was the one that stood out like a

sore thumb. And, you know, we talked about it last meeting, and you said you looked at it and you didn't see anything. But there were some variations in the pattern between the different hospice providers. Maybe they were local carrier decisions, but maybe we could uniformly get everybody on the same level playing field with administrative contractors.

I really think, Kim, you kind of pointed out a little bit about maybe we need a little bit more supervision or looking at the fiscal intermediaries, the medical contractors.

But, again, what I want to stress here is that there is no precision in determining end of life. We all have our decisions. We all think we know what is going to happen. But sometimes it doesn't work. And as a doctor, when a person lives a little longer and has quality of life, we pat ourselves on the back and said, great. We did a good job.

Thank you.

DR. SCANLON: Three quick points. First of all, I agree completely with you, Glenn, in terms of the idea of budget neutrality. One of the things that you are talking about in proposing a payment system change to policymakers

is that you have got to -- there is a level of uncertainty about what the impacts are going to be, and you really need to be reassured that we are not going to cause harm. And so to combine sort of the idea that we are going to both take away money and restructure things increases the risk of potential harm. There are examples you can point to where we did things budget neutral and over time we have made adjustments that have improved upon the efficiency of the system. So I think it is a wise thing to do this in stages.

The other two things: One is, I guess, in terms of the text of the chapter with respect to oversight, I think that we should emphasize that we are not proposing that these medical reviews in the third bullet in 2(a) be the only medical reviews that are going to be done. These should be in addition to medical reviews that are currently sort of underway, because one thing you don't want to do in terms of program integrity is to say here is exactly what I am going to look at, and so if you do anything else, you are going to be fined. You want to be able to have some more targeted options in terms of review.

The last thing is with respect to sort of the issue of the nursing homes. To me it is not just a question

of conflict of interest, though there may be an aspect of that. To me it is more of a question of does residence in a nursing home change the hospice benefit, even in the best of circumstances. And does it change it in a significant enough way that you need to think about a payment system that differentiates between residents of nursing homes and non-residents of nursing homes?

I think that we have been handicapped by a lack of data about actually what services are being provided. But to the extent that we can explore that, and maybe some for the fall, and then as data comes in in the future, that to me should be one of the questions on the table: How is the nature of the benefit changed by residence in a nursing home?

MR. HACKBARTH: One of the things I want to accomplish in this round is try to build towards changes, if any, in the recommendations so we can get people to react as we go through the queue. So what I hear Bill putting on the table is a couple points that I would like people to react to. One is stick with the budget neutrality language, but we could have a discussion in the text that expresses our concern about the trends, and we think that there may well

be opportunities through the update process, and after the payment system is in place, to reduce projected future expenditures. So people shouldn't interpret budget neutrality as we think aggregate spending levels are just fine, but we are advocating that as part of the appropriate way to do a payment reform. So that is one idea to react to.

The other is to go to broader language in the third bullet of 2(a) and then to have some discussion in the text about the need for medical review of the activities here. So if people will react to those as we go through.

DR. STUART: Bill raised the point that I was going to raise. You've made clear that recommendation one applies only to home care hospice, and as I recall from the text in the chapter, that is about 82 percent of hospice patients. It is the majority of hospice patients.

DR. MATHEWS: I think more than that. It is over 90.

DR. STUART: But the point I want to make here is that the way the chapter reads, we go up to the information that supports draft recommendation one, and then there is a short section that talks about institutional hospice care.

And then that is followed by recommendation 2(a) and 2(b), and the implication is, well, we can handle the issues in institutional hospice care through these reviews on a case-by-case basis, but there is really no discussion about how we are moving toward payment reform in the institutional care. And so I guess it really is the point you were raising, Mark, that this is something that is on the desk for future review.

I will say on the budget neutrality issue, because this is, I think, really important, I would like that to be an issue in and of itself. I would really like to see what has happened to each of these as we have gone, starting with PPS for the hospitals, and then moving onward, what the impact of starting with budget neutral and then changing that afterwards. Because my take on this is that in almost every one of these cases, there is just a real bloom in profitability right after the implementation, and then it goes down. Now, whether it goes down because of what, I am not sure. I mean, clearly there is a reaction/counter-reaction. But I think that it would be very useful for the Commission as a whole to have kind of that longer history and just to see how that has played out.

MR. HACKBARTH: I think that is a good suggestion, Bruce, and I think we all have remarked, led by Nancy, on the history of the post-acute PPS systems in particular very much fit the pattern that you describe. And so I think that is a real issue. The question I am trying to raise is do you try to do it in one step or in two steps.

DR. KANE: Just to comment on what you just talked about, the post-implementation period represents high profit, but then what you see is rapidly rising cost, you know, following those high profits, the ability to spend more money. So I do think we should think about it because I am not sure we are really lowering -- I am not sure we are really achieving the kind of cost savings that we would like to achieve. And I agree with Bob that it is not clear to me why you would start to pay more for the early phase if, in fact, people are -- that is not why people are losing money now. I think we need to know better why there are losses in some hospices and whether it is because they are only short-stay patients.

We also don't really like short-stay hospice, so I am not so sure we want to reward those either, and I am very concerned that we might sort of do those little three-day to

two weeks, more of those, instead of achieving of what we really would like to see which is a dignified, home-based, end-of-life experience.

I was reacting a little bit to your comment about marginal costs and having tried to actually do that in life, I don't recommend it because in the real world it is really a function of how people are hired. This is a very labor-intensive service, and if people are hired on a per diem basis, they are marginal. If they are hired on a salary basis, they are fixed. You don't want to go there.

But I think what is really driving the curve that I see is the skill mix and the number of visits, and you want the payment system to reflect the skill mix and number of visits at different stages of the episode. And perhaps that would be a better principle to work off than this kind of nice economic notion, theoretical notion of marginal cost, which you can almost never get to in the short run. In the long run, everything is marginal. So I would just say aim to try to reflect what the normative visit and skill mix is throughout the episode as a payment device rather than some theoretical marginal cost.

Then my final comment goes back to what Ron was

saying about how important it is to really try to -- I think the hospice benefit was really there to try to get people in before the amazing, enormous expenditure on the acute sector that many people feel are wasteful. I know it is a very tough issue, and, therefore, we are trying to not deal with it. But it seems that that is the issue. That seems to me far more important in some ways than the long stays, is the people who don't get in or get in for the last two or three days. I know it is hard, but I am just wondering if more reflection, more investigation, more discussion will give us some way of thinking about how do we try to bring the system to doing the right thing rather than, you know, overtreatment and excess expenditure in the acute sector at the end of life.

So I don't have the answers, but it seems like we dismissed it saying it is just too hard, and I don't think that -- since that is what we really want this benefit for, I think we need to think harder about how do we get providers and families and beneficiaries to be more aware and more willing to accept that this is the end of life and let's do something that is more dignified than what can happen.

DR. MATHEWS: In the expert panel that we convened in October of last year, we had four major agenda items, and one of them was this very question of what are the causes of the very short-stay patients and what can be done to try to change those three-day stays to ten-day stays or two-week stays and begin to move the distribution that way.

DR. KANE: But we don't really address it very much in the payment.

DR. MATHEWS: That's correct. The short version of what transpired in the panel was they were not optimistic. And we can have a conversation off-line about some of the detailed things they discussed, but there is a reason that it is not reflected fully in the paper.

MR. EBELER: This is terrific work, and I am supportive of the recommendations. Two comments, then a suggestion.

On the budget neutrality question, if we go back to the history, PPS was budget neutral, but it was budget neutral against what was called the TEFRA baseline, which was a set of very, very aggressive hospital cost constraints that had been enacted in the previous year. Likewise, RBRVS I think was budget neutral, but we had in the interim taken

several whacks at specialty payments. So there is also a history of some sort of arbitrary directional cuts before one implements the prospective system.

In hospice, we haven't mentioned it, but I would note that we still have the hospice caps in place and would presumably remain in place until 2013, and which capture the -- recapture some of the payments that go out for these exceptionally long stays. So I think when we are talking about budget neutrality here, it would be neutrality including the recapture that comes from those caps.

Second, if you would go to recommendation 2(a), this text comment at the bottom, I think more generically in this report we do need to continually point out that CMS is a very resource-constrained agency that everyone is asking to do a set of very, very innovative things, and I think we need to speak very clearly that if we want this program run right, we are going to need to resource it.

On bullet point three, I want to just make a suggestion that I think captures what Bill has suggested. The policy in bullet point three is that for outlier stays at hospices that appear to have a lot of outlier stays, we want medical review. That is the policy statement here. My

suggestion for us -- we are going to need something to vote on -- is that we insert the word medically before reviewed, and then delete everything from by the applicable up to for. So that is says require that all stays in excess of 180 days be medically reviewed for hospices for which... and then go on there. We don't say who does it. We just say we want it to be medical and we want it to be at these targeted places.

I hope that captures what you would suggest.

MR. HACKBARTH: I see some heads nodding. If we can nail that down, does that make sense to people?

[simultaneous inaudible discussion]

MR. EBELER: We want them reviewed. The mechanism for review I don't -- I think --

MR. HACKBARTH: Not reviewed by the hospice.

MR. EBELER: Not by the hospice. I'm sorry. Yes, that's right.

MR. HACKBARTH: We're okay on that point. People feel comfortable on that.

MR. BERTKO: I'm just going to quickly support your idea, Glenn, of the two-part, first make the change to redistribute, and then go after the budget-neutral part of it; and point out in Jay's -- the thing that he pointed

here, that there is apparently some reason to pay more for those very short stays. I've heard that also from several hospices, but that is one of the places in the U-shaped curve that probably needs immediate attention.

MS. HANSEN: Thank you. Yes, I support the changes that have been recommended, and after hearing the discussion about the two-part aspect, I would go along with that.

The one question I would have as we have this great work in this chapter, I wonder if there is content related to quality about the hospices. I don't know if there is any text at this point or some measures, but part of it is what services beyond the individuals that we have. So I wonder if that could be in the body of the text relative to the quality aspects of hospice.

MR. GEORGE MILLER: Thank you, and again, I want to congratulate the staff on excellent work in this chapter. I can support the recommendations. Jennie just covered my issue about quality, and I will check that off. But I agree with that.

Along with the quality, it seems to me -- and I agree with Ron this is an excellent benefit. We certainly

don't need to throw the baby out with the bath water. But using your metaphor, the water needs to be changed and it is toxic with some of these actors, and I am concerned about them. And I think that a part of it is -- I don't know if we put in the text, but there also needs to be some education of the beneficiary. This is a great benefit, but the way some of them are getting this benefit may be misleading from some of the evidence. It reminds me, if this is a good metaphor, of the credit card industry. They want everybody to get one, and then they do other things with the interest rates and those types of things to get everybody to get -- including my three kids, get offers for credit cards. Nonetheless, the benefit is great if the beneficiary is properly educated about the benefits, what hospice can do and should do for them at the appropriate time. So I would imagine we need to put that in the text.

But, again, just to emphasize the point as we look at this benefit and this cost -- and I would agree we need to study it over time. But I am concerned about the statement about budget neutrality that I think either Jay or Bill brought up, and we will address it at the appropriate time.

Thank you.

MS. BEHROOZI: This is an incredible amount of work you have done in a short period of time, and as I often hesitate to ask you to add a little thing, I will get to that in a second, just to address the budget neutrality point.

A point that you have made very clear is that there are probably beneficiaries receiving this benefit who shouldn't be, because they exceed the length of stay, exceed, exceed, and then they ultimately leave and maybe come back again. You know, we won't talk about Mike's grandmother, but -- so that extra money associated with those extra people in the system, it is not just that their stays are too long, but they shouldn't be in the system. And one of the things you're trying to do with changing the payment methodology is to have hospices select in the first instance more appropriate patients.

So if that reduces the number of people in the system, it does seem kind of odd to then take all that money that is associated with all those extra people and redistribute it to the beneficiaries that are left, to the providers who are treating the beneficiaries who are left.

So it seems like some kind of adjustment to the budget neutrality is in order, and maybe what Jack said about the cap addresses that. And I can't think of any other way to address that. It is not just a matter of, you know, reducing profitability. It is about keeping people in a more appropriate end-of-life setting. So that is a thought on budget neutrality.

The thing that I would suggest adding, it is kind of minor point, but could you put up recommendation 2(a), actually the -- I'm sorry, 2(b). This is a little bit, I guess, spurred by what Peter said about having the OIG come knocking on your door is a big deal, particularly for those who would be targeted by the third and fourth bullets.

If you could go to the next page where it says there is no spending implications, I get that that is the way the CBO would score it, and I wouldn't -- and we are not making any recommendation of action in those bullet points. But I do think in the text it is worth saying that we would anticipate -- I would anticipate; I don't know if you would agree -- a sentinel effect on the far outliers. And it is just the far outliers, and it is not core to the program, and possibly an impact that would be protective of

beneficiaries, as George says, because, you know, you make the point earlier in the text that maybe people who are targeted may be cognitively impaired or whatever, and they have to give up treatment for their terminal condition, which may or may not be their choice, may or may not be the best thing overall. But they may be robbed of a choice by virtue of some of that behavior that would be kind of tamped down by this sentinel effect.

MR. BUTLER: Well, us first-timers weren't here for the panel. I wish I had been. But listening to all this, I think, again, what everybody else has said, of all the things I've sat through in the last year, I think this is an exceptional kind of contribution that we're making, and I would like to acknowledge that. And as I think about my nitpicking on some of these recommendations, I am deciding I am not concerned at all. Yesterday, we had to be precise and feel like we are doing the right thing. Here I think to throw out a broad range of things to advance the discussion is very good, and we shouldn't worry about if we are little bit off on some of these. We've created a baseline that is very robust, and we will have plenty of dialogue in plenty of places. So I am very supportive of

it, not really concerned about the wordsmithing so much. So I am supportive of the recommendation.

The second thing, though, that I'm feeling uneasy about -- and it was triggered first by Ron -- is that of all the benefits we look at -- and this is largely Medicare expenses -- it is not just a financial statement about trying to use resources at end of life. It is kind of a social statement of how we handle end-of-life issues in this country. And we don't kind of capture how we can advance the softer side of this, not just the mechanics of this in a way that create the kind of dialogues. And I don't know how -- we don't typically make those recommendations because it comes down to budget kinds of things. But if there's a way we can capture some of that, I think that would be important.

Along those lines, and also along these lines, of all the areas where I would like to hear plenty of public comment and dialogue, this is a good one to hear from the constituencies that can help educate us as a group.

DR. CHERNEW: This is a really a round one comment, which is related to something that Bill said at the very beginning of this round, which is I am confused as to

what Part A and Part B services are foregone if a person is in hospice and how that is actually enforced. And I am interested in how that then is bundled with the nursing home set of services.

DR. MATHEWS: The foregone services are those curative treatments related to the terminal condition, so the --

DR. CHERNEW: But other treatments that are either not curative -- so palliative treatments or things that are not related to the terminal condition are -- so we don't know exactly how much Part A and Part B services are being used by hospice beneficiaries.

DR. MATHEWS: That is correct.

MR. HACKBARTH: Okay, this has been a good discussion. We are about 15 minutes behind schedule, and this being Friday and people having planes to catch, we really need to finish the day on time. So we have got to bring this to a conclusion.

I want to offer two proposals based on the discussion for modifying the recommendations, and let me do the easier one first. On 2(a), what I would propose is the Ebeler amendment, which is to say in that third bullet that

all of the stays should be medically reviewed and then drop the detail, and in the text we can make it clear that, you know, we are talking about external review and not just the hospice review. So that is the change.

Now, if people want to see the actual changed language, we can defer the vote until after the last discussion. I think that one is pretty simple and doesn't really require us doing a new slide. Are people comfortable voting that way? Okay. So that is 2(a).

Then go to draft recommendation one. This one is a little bit more complicated -- not the change, but the issues raised are inherently complex issues. My proposal for changing the recommendation is simple, which would be at the end there where it talks about budget neutral, say budget-neutral manner in the first year. Add the words in the first year at the end. And then add in the text a paragraph that (a) makes it very clear that that shouldn't be interpreted as satisfaction with the level of spending or the growth in spending in hospice; and (b) says that there are other policy tools that can be used between now and 2013 and afterwards to address the level of spending, including updates, the cap, and medical review.

Let me stop there. I will just end up repeating myself. So that is the proposal that I would make.

DR. KANE: What's the timeline on when our recommendations are required to be -- just refresh my memory of why we have to vote on these as is today rather than in March?

MR. HACKBARTH: The only reason would be to include them in the March report as opposed to the June report, which has been our goal. I don't know what it would do logistically to defer a final vote to March and putting this in the June report as opposed to the March report.

DR. MARK MILLER: It does mean it doesn't go into March, and then whatever agenda that we have for June -- and some of it is mandated -- there are a couple mandated reports we have to work through. So it starts to --

MR. HACKBARTH: Push other things off the plate.

DR. KANE: My only concern is really I think some of us did say we are not sure you should increase the payments equal and offsetting the ones you reduce and that we are not sure the lack of profitability relates to the early stays as opposed to just maybe something else like low volume. I guess that is -- I got the feeling we don't feel

-- I don't feel fully informed about the increased payment per day at the beginning piece that is equal and opposite to reducing the payment at the end -- at the middle, I mean.

DR. MARK MILLER: But remember, we are not -- the illustration that we put up on the slide that shows an equal, you know, beginning and end is just that. It is an illustration.

DR. KANE: I think the budget neutrality sort of says basically what you take away from the end where we -- from the middle where we think it's overpayment. You add to places where we are not sure it is overpayment -- underpayment.

MR. HACKBARTH: I think I understand your concern, and I think it is a good one. What we have done is lay out a concept about what the weights ought to look like. We haven't proposed specific weights, but we have suggested this U-shaped curve, which basically is a system of relative values. And we are saying the early days should be more highly paid than the middle days and so on.

That is not a statement about the absolute value of the rates during the early days and whether it ought to be higher than today or lower than today. You know, to use

the language of the Physician Payment System, that would be a question of the conversion factor, not the relative values. So I think our recommendation is one of a conceptual recommendation about the relative values and what that shape ought to look like. And what we are saying is the conversion factor is a separate issue. And the paragraph I have described says we have some concerns about the conversion factor, some concerns about the aggregate level of spending and the growth in spending, and those ought to be addressed through other policy measures like updates and cap and medical review in the interim.

So I wouldn't view the U-shaped curve that we are talking about as advocacy of higher payments than the existing level. It may work out that way; it may not work out that way.

DR. KANE: Then your language would have to not say increased payments per day. It would have to say have the payments per day be relatively higher than those of the length of --

MR. HACKBARTH: I think that is a good suggestion.

DR. SCANLON: If people were comfortable with that kind of a change, I think it is important, if we can, to get

this into the March report, because the March report has hearings associated with it. And getting this before the Congress as they are considering this year what they are going to do with Medicare, it is important that they think about this.

MR. HACKBARTH: I think that is an excellent point, Bill.

MR. EBELER: And we're not going to have the data to answer your question until 2010 or 2011. We are not going to have that in March.

DR. KANE: I'm happy with the language that doesn't say increased payment but says have payment in the early stay relatively higher than payment in the -- just change that word.

MR. HACKBARTH: We're going to move to a vote in just a minute. So, Nancy, do you want to state very clearly your rewording of that language?

DR. KANE: That we recommend that payment in the beginning of the episode be higher than payment per day as the length of the episode increases, and that payment at death should be relatively higher than payment in the middle of the episode.

MR. HACKBARTH: People have got that and feel comfortable with it? Mark?

DR. MARK MILLER: See if this captures it. I think it is fewer word changes. What you do is you substitute increased with relatively higher at the beginning. So it would say relatively higher payments at the beginning of the episode, relatively lower payments per day as the length of stay continues, and then in the second bullet it says relatively higher payment. Okay? And it's just a couple -- right, we are just swapping out a few words on this.

MR. HACKBARTH: Okay, any questions of clarification about that? We are going to vote in just one minute. We are going to vote in ten seconds. We are going to vote now.

[Laughter.]

MR. HACKBARTH: On recommendation one, all opposed to recommendation one? All in favor? Abstentions? Okay. So recommendation 2(a) with the Ebeler amendment in bullet three. All opposed to 2(a) as amended? All in favor? Abstentions?

Recommendation 2(b), all opposed? In favor?

Abstentions?

And Recommendation three, all opposed? In favor? Abstentions?

Okay. We are done. Thank you very much.

Next is our MIPPA mandated report on Medicare Advantage.

MR. EBELER: If folks could take their seats. We need to move along here. We're a little bit behind time.

Scott, when you're ready, you should...

DR. HARRISON: Good morning. Today, I will present some preliminary simulations for the Medicare Advantage payment report that was mandated for us in MIPPA. Remember our mandate: We've been assigned three specific tasks. Over the past few meetings, we've discussed evaluating CMS's measurement of county-level fee-for-service spending, and the correlation between that spending and MA plan costs as represented by their bids.

At this meeting, we are examining alternate approaches to MA payment in addition to the county fee-for-service approach. I am first going to remind you of MedPAC's past position and recommendations on Medicare Advantage payment, and then I'm going to discuss some

alternatives and present some simulations of the alternatives.

MedPAC has a long history of supporting private plans in the Medicare program. The Commission believes that the beneficiary should be given a choice of delivery systems that private plans can provide. Private plans, through financial incentives, care coordination, and other management techniques, have the potential to improve the efficiency and quality of healthcare services delivered to Medicare beneficiaries. And if the plans are paid appropriately, plans would also have the incentive to be efficient for the Medicare program and for the taxpayers that support Medicare.

However, MedPAC has expressed concern that the payment system is not financially neutral in a beneficiary's choice of enrolling in an MA plan or remaining in fee-for-service Medicare. Because the system does not adhere to financial neutrality, excessive payments to plans have been attracting inefficient plans to Medicare Advantage. More specifically, Medicare is paying 14 percent more for beneficiaries to enroll in a plan than it would cost to cover those beneficiaries under fee-for-service Medicare.

The extra cost has been subsidizing plans, often private fee-for-service plans that are not designed to coordinate, care, and improve quality, and even the subsidies are not spent efficient efficiently, especially those for private fee-for-service plans. The Medicare program pays a subsidy of $3.26 for each dollar of enhanced benefits for private fee-for-service enrollees. That subsidy is funded by taxpayers and by higher Part B premiums paid by all Medicare beneficiaries, whether they are in MA plans or not.

So, to address the financial neutrality concerns, the Commission recommended that Congress set Medicare Advantage benchmarks at 100 percent of fee-for-service costs.

MIPPA asks us to examine alternate approaches to MA payment. Specifically, we are asked to examine approaches other than the approach using payments based purely on county-level fee-for-service spending. In previous meetings, we have discussed enlarging the payment areas to create greater stability and to better approximate insurance markets, and we have discussed using a blend of local and national fee-for-service spending to set the benchmarks. Today, we will simulate some alternative

benchmark setting formulas, including the blend.

For today, we simulated the effects of five different formulas that could be used to set benchmarks. First, we looked at current law and we looked at one version of our prior recommendation that would set benchmarks equal to 100 percent of local fee-for-service spending. These two options serve as good points of comparison.

We also examined simply setting all benchmarks across the country at a 100 percent of the national average fee-for-service spending.

In addition, we looked at two approaches that use both national fee-for-service spending and local influences. First, we took the national fee-for-service average and adjusted it for local price differences but not for utilization differences, and we simulated the 75 percent local/25 percent national blend that aims to recognize plan costs, which we discussed last time. I will now go into more detail on each alternative.

I'm going to show you a series of simplified graphical representations of each of the formulas. Imagine the counties arrayed along the bottom in order of fee-for-service Medicare spending in the county. The corresponding

benchmarks run up the site. So, a point on the graph would represent the fee-for-service spending in a county and the benchmark for that county under whatever alternative we are discussing. Here, the orange line represents setting the benchmark at 100 percent of the county or local fee-for-service spending.

The yellow lines show the simplified relationship between fee-for-service spending in the current benchmarks. Basically, the benchmarks cannot go below the floor, and above the floor, benchmarks theoretically are slightly above local fee-for-service spending. For visual simplicity, we are ignoring the fact that there are actually two floors, and that benchmarks can be significantly above fee-for-service if spending in the county has grown slower than the national average at some point since 1997.

Now, we're going to add a horizontal green line that represents setting all the benchmarks at 100 percent of the national average fee-for-service spending. In our simulations, the current benchmarks are always above the national average, but the national average is higher than fee-for-service spending in most rural and in many urban areas.

For some of the highest fee-for-service spending counties, this means that their benchmarks would decline by several hundred dollars per member per month, while some of the lowest spending counties would have benchmarks a couple of hundred dollars per member per month above their fee-for-service spending. This option has been suggested to resemble how payments work in Part D. In Part D, all plans are paid the same rate across the country; however, the benchmark is set by the average plan bid, not average fee-for-service spending.

Here, we look at using the national average fee-for-service spending to set benchmarks, except that we adjust the average to recognize local differences in the prices of health service inputs. We use the two primary Medicare price indices, the hospital wage index, and the geographic adjuster that is part of the physician fee schedule. This formulation would set benchmarks higher in areas where plans might be expected to have to pay providers more, but would not set higher benchmarks based on higher service utilization.

The cloud around the national average line illustrates that there is almost no relationship between

local fee-for-service spending and local price levels. Areas with similar prices can have very different fee-for-service spending patterns. This alternative would keep the range of benchmarks to a fairly narrow range relative to the range in local fee-for-service spending.

Note here that we've added points representing Minneapolis and Miami. Despite the fact that fee-for-service spending in Miami is about $400 per month higher than in Minneapolis, average prices are about the same. And actually, if the benchmarks were set at the national average price adjusted fee-for-service spending, Minneapolis would have a slightly higher benchmark than Miami.

For the last alternative today, recall that Congress asked us to look at an alternative where the benchmarks might recognize the underlying costs of plans. The last time we presented on alternatives, we found that a blend of 75 percent of local fee-for-service spending and 25 percent of the national average fee-for-service spending best approximated plan costs as expressed by plan bids. The white line here represents a 75/25 local/national blend. Benchmarks in areas with less than national fee-for-service spending, say, rural Nebraska, would be higher than their

local fee-for-service spending in areas with spending above the national average -- Miami, again, for instance -- would see benchmarks lower than local fee-for-service spending.

We modeled each of the alternative benchmark formulations with data from 2009 plan bids. We included all plan types, but we have excluded special-needs plans and employer group plans because they are only available to subgroups of Medicare beneficiaries. The results I will present assume that plan bids and service areas do not change. Of course, we would expect that any overhaul of the benchmarks would cause plans to change their bidding strategies, but we do not model any behavioral assumptions. We could imagine, however, that any change that would result in the reduction of benchmarks is likely to cause some plans to leave the market and beneficiaries to refrain from joining plans who do not pay far enough below the new benchmarks to offer more attractive benefits.

The simulation results that follow focus on plan availability. We compare plans 2009 actual bids with the new benchmarks that result under each alternative. We assumed that plans that bid below the simulated benchmarks would continue to do so and therefore be available, although

the extra benefits they offer would probably be reduced. We assumed that plans bidding above the benchmarks would not stay in the program because they would not be able to offer attractive benefits, although there are some plans that have bid above the current benchmarks and remain in the program.

So, the results today are based on very simple assumptions, and to maintain simple assumptions we performed the simulations at the county level not at the level of our larger recommended payment areas.

So, we simulated the benchmarks for each county under the alternatives below. The current benchmarks average about 118 percent of fee-for-service. Each of the alternatives would result in an average benchmark of around 100 percent of fee-for-service. This reduction, regardless of the distributional effects, will cause a big change in plan availability. The plan shows the percentage of Medicare beneficiaries who live in counties with zero, one, or two or more plans bidding below the simulated benchmarks. Aside from rounding issues, each row here sums to 100 percent. Currently, 100 percent of beneficiaries live in counties with two or more plans bidding below the benchmark.

Under our simulation rules, if benchmarks were set

at 100 percent of local fee-for-service spending, than 19 percent of beneficiaries would be in counties where no plans bid below the benchmark, 12 percent would be in counties with one plan bidding below the benchmark, and 70 percent would be in counties with two or more plans bidding below the benchmark. This is the option that had the largest effect on the simulated plan availability.

The alternative that the least impact on the availability of plans bidding below the benchmarks was setting all benchmarks at 100 percent of national average fee-for-service. The simulations show that only 6 percent of beneficiaries live in counties where no plan bid was below the national average. The two alternatives that aimed to recognize local price differences or plan costs had intermediate and similar impacts to each other.

For more analysis, we will take the first column here and break it into urban and rural numbers on the next slide, but before I leave this slide, I want you to focus on the 90 in the right-hand column. It says that 90 percent of beneficiaries would have two or more plans available if all benchmarks were set at the national average fee-for-service. What it can't to you is what kind of plans they might be.

In rural areas, private fee-for-service plans still have room to operate between low county fee-for-service rates and the national average, which can be substantially higher. In high fee-for-service urban counties, they may be plans that bid way below current benchmarks and were able to offer attractive, enhanced benefit but might be just below the new benchmark and can only offer minimal benefit enhancements under the national average alternative.

DR. MARK MILLER: If I could just say, because I want to reinforce this point, in particular. You look at something like that and you see, well, 90 percent. So, what's the problem? That could potentially be an option. But there could be plans in those areas but the extra benefits that they could offer would likely be very different than what they're currently doing. So, how many of them and how attractive they would be to beneficiaries over time would be a real question. Whereas, at the other end, the likelihood, meaning low-cost fee-for-service areas -- the likelihood of those plans would have much greater opportunity to offer extra benefits.

And so, over the long haul, what it does to plan distribution I think is not well represented by this

simulation.

DR. HARRISON: Now, this slide shows the percentage of beneficiaries who would not have a plan available under our simulation assumptions.

The second column shows the percentage of urban beneficiaries who would not have a plan in their county, and the third, the percentage of rural beneficiaries who would not have a plan. As we saw in last slide, 19 percent of beneficiaries would have no plans bidding below 100 percent of local fee-for-service. The effect of the 100 percent local fee-for-service alternative would be very different in urban and rural counties. Fifteen percent of beneficiaries in urban counties would have no plan bidding below the benchmark, compared with 31 percent of the beneficiaries in rural counties.

Now, because about 80 percent of rural beneficiaries are in counties with fee-for-service spending lower than the national average, rural benchmarks are higher when there is greater reliance on national average fee-for-service than on local fee-for-service spending levels. Also, the floor in rural counties is near the national average fee-for-service spending, so plans that are there

now are generally bidding below the national average.

Now, perhaps less intuitive is that beneficiaries in urban areas are also more likely to have plans available under the 100 percent national fee-for-service alternative. As it turns out, about 55 percent of urban beneficiaries are in counties with fee-for-service spending below the national average. So, we have kind of a skewed distribution where you have a few large urban counties that have much higher local fee-for-service spending.

Now, while the simulations suggests that fewer beneficiaries would have plans available under the 100 percent local fee-for-service alternative than under the national fee-for-service and the blend alternatives, there are still some policy issues about the types of areas where plans would be encouraged. We might undercut plans in high fee-for-service areas such as Miami-Dade County where they have the potential to be efficient for the Medicare program. At the same time, we may encourage plans to enter low fee-for-service areas, such as Marathon County, Wisconsin, where fee-for-service may be the most efficient way to provide Medicare benefits.

On this slide, we have the current benchmarks, the

100 percent local fee-for-service figure, and an approximate national fee-for-service figure. There are about 80 plans in Miami-Dade that are bidding far enough below fee-for-service to save Medicare money on their enrollees. If Miami's benchmark was set to the national average, $720 in this example, we would probably force out a plan that bid, say, $800 per member per month, even though that plan would cost the Medicare program significantly less than the cost of keeping a beneficiary in fee-for-service in Miami.

At the same time, we would encourage plans in Marathon that bid $650 a month, even though that plan would cost Medicare significantly more than covering the Marathon beneficiary in fee-for-service Medicare.

Let me briefly summarize the findings from the simulations. First, a caveat, again, about the simulation assumption: We assume that a plan would be available if bids below the alternative benchmark -- I'm sorry, that plans would be available if a plan bids below the new benchmark, and unavailable if it bids above. In reality, if a plan knows it would be bidding above the benchmark it could one, withdraw; two, stay and charge a premium; or three, shave costs and bid lower. So, more plans might be

available than our simulations show in some cases.

At the same time, if a plan is only bidding slightly below the alternative benchmark, it might decide it cannot be competitive with fee-for-service Medicare, and then it would withdraw. This would be especially true if it did not have much enrollment in the area. So, in some cases, our simulations are likely to overstate plan availability. That being said, it is safe to say that all alternatives reduce average benchmarks to 100 percent of fee-for-service spending and result in lower spending and in reduced plan availability.

Of all the alternatives, 100 percent local fee-for-service benchmarks have the most impact on availability, and the 100 percent national average fee-for-service average benchmark, the least. The different alternatives may have different effects on urban and rural areas, as we've shown, and alternatives other than the 100 percent local fee-for-service option would continue to encourage the entry of inefficient plans in some areas.

Now I'm seeking guidance for further work. I'd like to know what other simulations you would like to see. We can show you results by plan type and we can use our

larger payment areas instead of counties, but we will need to make some planned behavioral assumptions in situations when a plan has submitted bids for some but not all of the counties in a payment area.

I'd also like to know whether there is other metrics other than availability you would like us to simulate.

Another question is, should we simulate some formulations that use plan bids to set the benchmarks? This would require us to make some behavioral assumptions because plans usually submit multi-county bids and we need a way to determine how those bid should be translated into single-county bids that would be needed to set the new benchmarks. And are there other alternative formulations you'd like to see, such as hybrids?

Also, if we are to make any recommendations, we might want to lay out our goals for the MA payment system and for the Medicare Advantage program, in general. What should the goals for the program be? Should payment policy ensure that all beneficiaries can have a choice of plans? What trade-offs should we make between ensuring plan availability and how much we have to pay for that

availability? And can we use payment policy to encourage improved quality in Medicare? And are there any other things?

Thank you and I look forward to the discussion.

MR. HACKBARTH: Thanks, Scott. Could I kick off round one with a clarification question about slide 10.

I can't quite wrap my mind around this and the Minneapolis-Miami comparison, so you would you say one more time what --

DR. HARRISON: Okay. So, what we're doing is we're taking a constant, a national number; in this case it was $720. And we then adjust that for the GPCIs and for the area wage index, and that's it; that's the new benchmark. It turns out that --

MR. HACKBARTH: So, normally what we hear in the Minneapolis to Miami comparison is that, if you put them on a level playing field in terms of pricing and use a national standard pricing -- so basically, what you are comparing is utilization rates between the two. Minneapolis is much lower than Miami.

DR. HARRISON: Right.

MR. HACKBARTH: This is doing something very

different.

DR. HARRISON: Well, what this does is everything except the utilization, and that's why they're the same, and all the difference you see is utilization.

MR. HACKBARTH: Yes.

MR. EBELER: The payment would be the same, but Miami being far to the right on the x axis shows that their current costs are much, much higher.

MR. HACKBARTH: Yes. Right.

MR. BERTKO: But Scott, if -- I know this is probably not risk adjusted for the population in this particular diagram. The people in Miami, by many risk adjustment measures, look to be sicker. I'll use those verbs.

DR. HARRISON: I think that's right.

DR. REISCHAUER: So, this isn't the 1.0 person?

DR. HARRISON: Well, the local fee-for-service spending is for the risk of the population. Actually, this should be risk-adjusted.

DR. MARK MILLER: Yes, I thought the answer to the question --

DR. HARRISON: Yes, this should be risk-adjusted.

DR. MARK MILLER: -- this is Miami on the utilization -- because of utilization is to the right, risk-adjusted.

DR. HARRISON: Correct. Actually, the horizontal values wouldn't be risk-adjusted. This is just the national rates.

DR. MARK MILLER: Right, but those are payments. Those are payments.

DR. HARRISON: That's right.

MR. HACKBARTH: Let me see hands for a first round of clarifying questions.

MR. GEORGE MILLER: Thank you, Glenn. Excellent report.

In the text of the report, you talked about disenrollment and the impact and -- I didn't see any discussion about the impact of disenrollment on plans one way or the other. Can you eliminate or clarify if disenrollment has any impact on the plans and how we can --

DR. HARRISON: I'm sorry for the confusion.

MR. GEORGE MILLER: That's okay. So, disenrollment --

DR. HARRISON: The report isn't what we're talking

about today, even though it is for you to review, but we were done presenting on the report chapter, but we will catch up with you after on that.

MR. GEORGE MILLER: All right. That would be fine, then. Okay.

MR. BERTKO: Scott, just to confirm that this is modeling -- represents an ultimate, steady-state, new payment system, not any of the glide path part in between now and then.

DR. HARRISON: Correct.

MR. HACKBARTH: Let me see hands for round two comments or questions.

DR. REISCHAUER: I think this is great, Scott. As you say, the real question is, would plans, even though their bids are a little bit below, come forth with an offer that is attractive to the population.

I was wondering if we were going to do something like look at enrollment in plans, now, as a function of where they are relative to the benchmark, the bid versus the benchmark; they're just volume and then get some kind of idea about how big a gap, either dollar or percent, you need to make an attractive offering. And you could do this by

the type, like HMO versus PPO versus private fee-for-service and do this, and then you could get a better feel for the answer to your question, which you say you can't answer at all, which is, would all of them disappear, because the gap between the suggested new benchmark and what their bids are is only 2 percent or something, and we don't see any significant enrollment in those kinds of situations now.

DR. HARRISON: Yes, we can do that.

MR. BERTKO: A comment first, and this is just to reinforce comments that Scott and Mark made, and Bob, you were kind alluding to here, is the benefit changes that would come with this would be massive. And so, there would be some large amount of disruption in the way people think of things.

So, what Scott has presented to us, if I'm, again, interpreting it right is, what to the current bids look like and how would they survive if the bidding process and mechanisms went along the same way?

The question, I guess, and the suggestion for further work would be, could we look also at some mechanism which uses bids, Scott used the word hybrid, or otherwise, that would bring in planned bids to help set those.

So, rather than, for example, having some arbitrary amount, and I would take the, I think, last of your modeling there, the 75/25 bid, and use instead either reliance on a median bid, reliance on some other mechanism, a combination of the local fee-for-service rates or otherwise and see what that would do. Its main advantage, in my mind, is that it recognizes what each plan has to pay and recognizes the local patterns of care there.

Miami clearly has too much demand and too much utilization, and some of the plans have done a pretty good job reducing it; others have not made that great consequence.

The last comment is also an observation. Scott, when you talked about using the national average you referred to Part D. My main comment there would be, unlike part A and B services, Part D services where you buy drugs can be generally bought on a national basis. So, if you're buying an antihistamine, you can buy it for the same cost effectively everywhere in the United States, whereas both hospital and physician services, particularly hospital services, vary dramatically around the country. So, using a single national number, even with modest adjustments for

price inputs, is difficult, let's say.

MR. HACKBARTH: The other difference there -- I agree with that point, John. The other difference between Part D and this is that Part D, the only choices available are private plans that are participating under this system. In Medicare Advantage, you have people choosing between traditional Medicare and private plans, with traditional Medicare having a dramatically different cost structure, which is the policy problem we're grappling with. So, to draw the analogy to Part D just isn't apt to me. It's a different kind of choice that beneficiaries face.

DR. HARRISON: And there's also only 26 payment areas or something.

MR. HACKBARTH: Yes. On the first question or comment about bidding, we had an exchange about this, I think, after the last meeting.

I had actually interpreted statutory mandate as asking us to look at using bids as an option, because it refers specifically to looking at the relationship between plan costs and Medicare fee-for-service payment levels. I sort of leap to the conclusion that one of the options that thought we ought to look at is using bids as part of the

payment process.

And you saw it differently. You don't think that is one the options we were asked to look at. Would you just elaborate on that?

DR. HARRISON: I wouldn't say that I didn't think -- I wasn't sure whether we were supposed to use bids specifically. I definitely think it's an option and we could do it, but it will require you to trust the staff on the assumptions pretty broadly.

DR. MARK MILLER: Actually, if I could say something about this.

Decidedly, what the legislation said is you should use the bids to represent cost, and then it went on with language, and we were interpreting that as kind of the blend option.

Now, we actually have been working on bid types of strategies here. Given the limitations of our simulations and what we can do, exactly what they tell you gets kind of us squirrely. What we can do with you and with whomever else -- because it could get pretty hairy, the conversation, we can give you a better sense of what those real limitations are. But we're not completely tone deaf; We've

actually been messing around with this and some of the limitations of what you can say with a bid-based benefit are even more -- in my opinion -- even more limited than what you see here. And so, we can get you to that point.

DR. CHERNEW: I think this is wonderful. I think it's crucial to do this by plan types, absolutely crucial.

It's not clear to me whether more or less availability is good or bad by different types of plans and a bunch of things, and so, I think it's absolutely essential to do it by plan types.

Second, I think it's important that we do it by plan types.

Third, plan types are important.

And fourth, larger payment areas are less important than plan types, which are important.

[Laughter.]

DR. CHERNEW: Fifth is, you asked about other metrics you -- -- I'm interested in the magnitude of the difference from where the existing benchmarks, more so than just, is it above or below, or what it is. Because I think the magnitude of the difference tells me about how much the benefits are going to, much more so than when you were still

there and what you were doing.

So, if I had to pick, the first thing I'd look at -- I'd want to know how many counties -- sort of the distribution of the payment, relative to what they were.

I won't say much -- I was going to say a lot more about this benchmark by bids. I think the summary of what I just heard, and what I would have said for it is, you need a lot more behavioral and econometric analysis to be able to say anything about that scenario, and I would be skeptical of you spending a lot of time trying to do it in a way that later people will be skeptical of how you've done it.

So, although I think that's a wonderful way to do it, I would want to have a lot longer conversation about how that was done before sending you off to figure out what would happen if we did it by bids, because you need to figure out the plans are going to bid, how they are going to respond, what's going to happen. That's a very, very, very difficult thing to do, although maybe a decent policy option, but I would have to think through all the literature about how to do that.

I'll stop there -- actually, the last thing on just a general point, the current system has two features

which explicitly are not in here, which I just think you should be clear that they're not in here.

One of them is, they tend to say that your update is based on where you are now plus some update factor, so as opposed to that, it's just going to be 100 percent fee-for-service. It's more like, you have what you have now, plus the increase in what fee-for-service was, right?

In the current system, when they have five things like this, it works as a ratchet. You get the higher of blah, blah, blah, blah, blah. The way you've done this and the way it should be done is a little more absolute and a little more less ratcheting. I think that's the way you have done it, but because that's a different way than the current system, I think it's worth emphasizing that you didn't do it that way.

Plan type. Thank you.

MR. EBELER: First on, off of this chart, the red line is a conceptual -- we know it points up and to the right, but I think it would be useful at some point to know the real shape of that line. It presumably isn't a constant slope, county by county.

DR. HARRISON: Do you mean the yellow line?

MR. EBELER: No, the fee-for-service line, the 100 percent fee-for-service line.

DR. HARRISON: It's just a construction.

MR. EBELER: No, I know that. I'm just saying the real shape of that line would help us think about the implications of some of these options.

If you then switch to slide 17, I'm not sure Michael was clear enough. I would argue that we need plan types in this analysis. I do think looking at our standard -- MedPAC has a preexisting recommendation about moving to larger payment areas. I think it would be useful to look at that.

I think the other metrics is where we get into -- explicitly into the goal slide. I don't think the number of plans available is the goal. It strikes me that the metric one wants to look at is, are we attracting plans of the type that can change delivery and quality and service in the areas that are amenable to that change without getting -- without attracting on the other end a whole bunch of plans that can't improve things in areas where fee-for-service might be cheaper. That's the trade-off you're trying to see, but it's sort of getting the right plans to the places

where there's opportunities strikes me as the thing we're trying to do here. So that's what I would suggest as a metric.

The other alternative is something -- I don't know if, Scott, you mentioned it, or Mark had mentioned it -- but we had discussed at one point in the past, and there's all sorts of blends we can have here, but talking about a payment at the fee-for-service level in whatever the payment area we define, in the middle, for most places and defining a sort of a high and low point. There is a point where you would have a blend off of that, and at the high end, you would start coming down. But it's something to think about.

DR. HARRISON: You'd want to see that plan availability if we were to do something like that?

MR. EBELER: Again, we're going to be suggesting a set of analyses that are going to be impossible to do, but yes. So, that would be my walk through page 17.

MR. HACKBARTH: I agree the plan type is better than plan availability, but the reality is that plan types cover a wide array of different organizations. What counts is a coordinated care plan -- is really a wide spectrum of different organizations, a big range from Kaiser Permanente

to an IPA-type HMO that's basically discounted fee-for-service and contracts with, more or less, every provider in a market. They would show up as the same broad plan type, but their ability to do what you referred to, actually change patterns of care in a way that Medicare cannot, is very different. So, even plan type has its problems.

DR. DEAN: I, too, would thank you for the presentation. It's been a confusing area, and I think it is gradually becoming a little more clear.

I would say that we really need probably to step back, for me, at least, and go to page 18 because I don't know that we can answer any of these questions unless we really try to decide where we're going.

It seems to me that, originally, MA was introduced with the idea that if you brought private entities into the process, you would get innovation and cost saving. But then, we began to hear that there was unhappiness because it wasn't available in certain areas and it wasn't uniformly -- a beneficiary didn't have access to these kinds of things, and so, there were a variety of things done to increase the access. And then, there was the issue that, well, maybe it ought to be a mechanism to enhance Medicare benefits, and

certainly there is some appeal to that.

I think the whole thing has gotten very confused and, in fact, which of these mechanisms we try to proceed with depends very heavily on where we are trying to get to. And so, I don't know who makes that decision, whether we make that recommendation or whether that's something that Congress has to do or whatever, but it seems to me that we can't make any decisions about the mechanisms or what plan type works the best until we try to decide what our goals are, because I know that specifically the models that have certainly been most efficient in terms of controlling costs and efficiency are never going to be available in my area.

I mean, if you have a closed-panel HMO, they simply aren't going to be in central South Dakota, and that's just the way it is. I mean, we accept that; that's the reality, but we need to recognize that. We can't, I think, try to drum up the rules to force them into that area by paying them some exorbitant amount of money, that's not efficient for anybody.

Like I said. I think we really need to focus on what the goals are and get those clear before we try to make these other decisions.

MR. HACKBARTH: I agree with that, Tom, and I have some thoughts when we get through the queue.

DR. CROSSON: A couple of thoughts with respect on the last two pages, which are the questions that we've been asked to answer.

One novel idea is I would like to see the information displayed by plan type.

[Laughter]

DR. CROSSON: And to make it a little bit more complicated, taking off on what Glenn said, is it possible within the HMO plan type to develop distinctions based on the predominant delivery system? That would be one question. You don't need to answer that right now.

But we ought to look at plan type both with respect to the issue of ultimate availability as well as the financial impact on various types of plans.

I particularly would like to see it in the context of the option that's on page 10, which I'm still not quite sure I fully understand, but which looks like it has perhaps some more -- I don't know what -- flexibility than some of the other models. There might be more to it than I can see, but I'd like to understand it better.

With respect to the goals of the MA program, as Tom said, you sort of want to start with what you're trying to do and then work on the details. So, when Scott gave the presentation, he said the original purpose of the MA plan was to promote choice of delivery systems, and I think it was, actually, because, for example, for our own program -- and we were active at the time in talking about this issue, we couldn't see how an organization that provided full prospective payment to its delivery system was going to function well in a fee-for-service environment.

And so, the ability to have pre-payment blended very well with our basic business plan and philosophy and has proven to be valuable. And I think it has expanded to other similar types of organizations.

Is the situation the same now or is it different? Well, in some ways, for us, it's the same, in other ways, I think it's different. We've talked here at the Commission a lot about delivery system reform and the fact that there appears to be a relationship over time between the structure of the delivery system and how it's paid, and at least potential to achieve cost savings. So, I would posit, just for an answer to the question, that, at least as I think

about it going forward, the goal of the Medicare Advantage program -- one goal, one important goal -- is to support methods of prospective payment to delivery systems that have the potential, anyway, to increase quality and to increase efficiency, particularly through the use of preventive medicine, early detection of disease, and care coordination of patients with chronic disease. There may be others but to me that is one core goal of the future Medicare Advantage program.

DR. MARK MILLER: Nancy had to catch a plane and if I don't have this right we'll just deal with it off-line with her.

I think what she was saying in terms of the impact analysis, can we also judge, when we look at plan availability, how many beneficiaries are affected. So, it may be 16 percent of plans but how many beneficiaries are accounted for by the numbers of plans rather than just...

DR. REISCHAUER: In the chart showing you how many would have zero plans, one plan, two or more, what she wanted to know was the enrollment in those areas. So, as you pointed out these would be much, much smaller numbers of people would be affected by having zero plans in their area,

maybe.

DR. HARRISON: Right. This was weighted by people living there as opposed to people enrolled. Right.

DR. SCANLON: My comments relate to plan type, too, as well as the objectives. And it partly goes back to what Jack said in terms of the idea that there may be some benefit from coordination of care that's coming from the plan that is positive for both the program and the beneficiary. I think my comment comes into a series of questions.

The first one would be, as you pointed out, Glenn, there are plans that accomplish that and then there are plans that nominally coordinate care, and they don't, okay? So, the question is, can we actually identify and set standards for accountability to know that we got the kind of coordination that we would desire, because if not, I don't want to just open up a benefit for pseudo-coordination.

The second issue for me is, what is the cost of providing that kind of coordination? Because yes, there may be savings as one of the program benefits, but my suspicion is that the cost is very much through -- very great economies of scale related to the cost of doing this. They

are not just scale economies in terms of the number of people that you have in the plan which larger payment areas might be able to deal with. I think it goes to density, because you've got to be involved. If we took all of South Dakota as the payment area, it's a big deal to coordinate across all of South Dakota.

So, there's this question of, well, what's the relationship, the production function for the plan in order to provide this coordination, and should the payment policy reflect that?

The next question would be, is there a price which we would not be willing to pay to bring this kind of coordination to any locale because it just becomes too expensive? But if we value this service and think of it as of benefit to beneficiaries as well as to the program, and this goes back to our discussion in 2005, there may be circumstances where we are willing to pay more than traditional Medicare because we're getting something more than traditional Medicare, and we're going to, on average, either break even or save the program money because there is going to be other areas where the density of the population and the savings that were going to get -- Miami being the

case that is always cited -- are going to be so great that we're going to be able to subsidize this activity somewhere else. So it's a series of, kind of, ifs.

MS. HANSEN: Thank you. The areas really relate to the goals of the program, and since Arnie isn't here, one of the things he would always say is the highest value and quality for the least price. So, it seems to be kind of a factor of that. And hopefully have appropriate -- whatever that would be -- on program spending.

But my bulk of thoughts really centered around what Jay and Bill just said relative to, whatever the plan types are, is the ability to think of the big trunks of prevention, early detection, and management and effective chronic disease and excellent episodic care in that process? So it really defines delivery system and care coordination in that sense.

So, at this stage, the plan types and the relationship -- and this goes back to the chapter, in reading that, and I don't know whether this is the metric side yet -- it is more of a descriptive side of the relationship of the philosophy and alignment between the plan and the physician groups that oftentimes arranged that.

So, it may not be just the staff models, but are there other models that have been in practice now that produces some of the outcomes that we are looking for in terms of the ultimate beneficiary receiving prevention, early detection, effective chronic care management, and excellent acute management with this coordination?

So, I just wonder, to be agnostic about it for the moment, are there any indications of how best to take a look at possible settings that aren't huge, integrated systems that can still score well on these results? So, it is more of a, as they say, a much more descriptive side, but implicit in it is, does the beneficiary get the best front-end care, secondary prevention, and tertiary care? That should be, hopefully, to me, the ultimate outcome of using the Medicare funds appropriately and having the -- pay the least amount of money for the best result.

I think, related to just looking at the trajectory, how do we take a look at unique areas like South Dakota, when you have a very desperate environment where it's spread out?

As a sidebar, I know that our minor but still available PACE program is now in a demonstration project of

rural settings with capitated systems and that kind of environment. So, more is coming, but how can you do that in much more dispersed environments with a capitation approach? What does the delivery option look like? So, I know that is actually in process right now and so I just offer that.

Again, we always talk about the scale issue, and I well respect that, but right now that principal is looked at when you have spread-out populations but the ability to align philosophy and service.

So, just some thoughts to look at more on a kind of context background rather than -- we're certainly not ready for matrix yet.

MR. HACKBARTH: I want to pick up on this discussion of goals, and I agree emphatically with the statement that Tom and others have since seconded about the need to be clear about what our goals are.

I've been involved with this program and its predecessors as an academic advocate of the idea, a government official arguing for the legislation, the TEFRA legislation, '82, HCFA -- a government official implementing the program, a plan executive, a physician group executive -- I've seen this from a lot of different angles, and what

strikes me about the history of this is that, in fact, the goals have migrated over time in an unspoken way.

Initially, the goal, as Jay described, was to create an opportunity for different organization types to serve Medicare beneficiaries. And because the payment level was set at 95 percent of Medicare's cost, they had to do so in a way that was efficient. So, as a way to get out of the fee-for-service model, use different organizational and payment types in the name of achieving lower cost and more efficient delivery of care.

Over time, in subtle ways, the goal has migrated. We then went into a period where the focus became much more on, well, we've got to alter the goal to achieve geographic equity. And that meant a couple different things.

One was we want equal opportunity for beneficiaries in all areas of the country to get added benefits.

And second, and related, was the notion that we shouldn't be punished in Minneapolis for our efficiency and traditional Medicare, and not have the opportunity under Medicare Advantage and its predecessors to get more benefits for our constituents in those areas. So, geographic

equities started to become really important.

Then, that's migrated relatively recently to, well, what we're going to use as our metric is plan availability. We got to the point where we're counting plans. Is there a plan in every part of the country? How many plans are there? And it is total disregard for what the plan type is, what their capabilities are. It's just, are they out there, and then we've got to pay them enough to produce added benefits to have geographic equity. And so, what was a very focused idea about importing innovation into the Medicare program has morphed into, well, let's throw money at it until we can have enough plans everywhere that offer lots of benefits. That migration of the goals is really a problem, and it's always been a problem, but, boy, today, more than ever, it's a problem.

Now, we're about to see the leading edge of the baby boom generation retire with attendant financial stresses on the government and Medicare and we've got trillions of dollars of new federal obligations that we're assuming. We've got to get back closer to the original objectives for this program. So, that's speech number one.

Number two is that I support many of the ideas

about innovative delivery that can produce better value. The question is, well, how do we tell which organizations can do that? I don't think you can do it by looking at plan type documents or program brochures. You've got to assess it by looking at the data. Do they produce costs that are lower than traditional Medicare? Do they produce added of quality, improvements in quality, above what is the ambient in their community?

Because of the fiscal situation, I'd like to see us say traditional Medicare is the objective. If you can do it for less, by all means, come in; we want your help. But I'd be willing to say we're willing to pay more if you can demonstrate higher quality than exists in that community without your involvement. We will pay more for it. I don't care what your type is, but if you can improve quality compared to what exists ambient in that community, I'm willing to pay more for it. But we are not even close to those objectives.

So, I would like to see a sharp statement of re-focused objectives inform the payment option discussion as opposed to just producing tables on plan availability of different payment models. I think that's a really essential

for a good a policy discussion.

DR. CHERNEW: First, let me say I agree with that completely and there is a distinction between the marching orders to Scott about how you'd like to see analysis like this, in which case I think you have to work off of things like plan type, and the broader policy comments that I think you made, which I agree with completely.

The two things I wanted to say were, first, care coordination stuff, which I think is very important, has become a bit of a buzzword, and I do think it's an important part of the value added of health plans, but there are many other ways in which health plans can be innovative and add value, including refining payment mechanisms and a whole bunch of other things. So, I think when we think about when we look at plans and what we want to do, it's not just we want to have a bunch that coordinate care and do those things better, plans that can do a more efficient job by adopting better payment mechanisms or more efficient payment or better physician intervention things, better networks. If there was a plan that could come in and have a more narrow network and focus on physicians who we thought were really good, that would be a fine added value, even if they

weren't doing some of these other things. So I think we have to recognize there are important ways plans can add value, not just through coordination.

The second point is, and something that I think is important in the system is, if we had plans that were innovative and good in a range of ways, there's an advantage to the people who are never in that system. And I think we sometimes talk about someone who's choosing to be in, say, the traditional Medicare system or have the choice to be in another system, but because these systems are operating in the same places, often, then interact. And I think an important side benefit of supporting the Medicare Advantage program or the Medicare health plan program more generally is the efficiencies that potentially can be gained by the health care system overall if -- and this is a big if -- if one can encourage the development and diffusion of plans that are doing good things for the markets where they are, and I do think there are some of those.

MR. HACKBARTH: Other comments?

Let me just go to page 15, Scott. I haven't really studied this, but I think I understand the basic point here and I think it's an important one.

One of the concerns that I've had about the broad concept of, well, let's get to 100 percent of fee-for-service on a national basis by lowering the payments in some of the high-cost areas like Miami and increasing the payments in some of the areas where Medicare costs are low, and just average it out, is the dynamic effect of that. What is the signal that you're sending? And I worry if you cut the payments too much in Miami, and I'm guarded about this, because I think they can be cut somewhat without dramatically reducing plan participation and enrollment. But if you just whack and say, we're going to the national average, I think what you run is the risk that we will discourage plans in the areas where they can most make a difference and create lots of private fee-for-service plans in areas of the country where they don't do anything to promote care.

We could in theory have national 100 percent of fee-for-service expenditures, but our signal as to what we want to buy is just totally wrong and we're going to end up with a program that is worse than useless, because just think of what's going to happen in all those rural areas of America where we are encouraging everybody to enroll in

private fee-for-service. Basically, we will undermine traditional Medicare and it's payment systems. Over time, more and more people will migrate into add-no-value private fee-for-service plans, and Medicare's ability to set rates and do the things that it does will just disappear; it will be undermined.

So, just getting to 100 percent of fee-for-service on a national basis is a very simplistic idea. Conceptually, I can embrace it, but how you execute it makes a huge, huge difference in terms of the dynamic effects.

Any other questions or comments on this?

DR. REISCHAUER: If we wanted to go back to the future, you could think of stimulating something on the order of a national fee-for-service except in areas where local fee-for-service is higher than the national, and then 95 percent or 90 percent of local, because you want to some kind of incentive to generate the behaviors that you're suggesting.

DR. STUART: Just a quick observation. You mentioned this, but I think we may have lost track of it as we've gone through the discussion, and that is that these simulations are based only on the standard MA plans, the

coordinated care plans, and the standard fee-for-service plans. They include the SNPs and it excludes the employer-based plans. These are two beyond the traditional private fee-for-service plans, which are the fastest growing.

So, I think that, when you conduct these simulations, it's also, I think, imperative that we say, well, we're not doing simulations in these other areas. As many people have suggested here, you really do get into those behavioral implications of what these rate structure differences are going to have. It might well be that it would be -- people then would -- the migration into SNPs and employer-based plans would be even greater in order to avoid taking a cut in terms of pay, depending on where you are.

MR. BUTLER: One quick comment. I understand your last point about the whacking too much. And then, on the other hand, in the meantime, the private fee-for-service plans are growing rapidly and providing a lot of new benefits to people. It's going to be kind of hard to pull those back and retract and the stability for them.

So, short of a moratorium, I don't how you put the brakes on putting more of these things out there that are going to be hard to unwind. We ought to think about that.

MR. HACKBARTH: Well, of course, there was an effort to make the terms less favorable to private fee-for-service in the last go around.

I don't know, Scott, if you have any comment on the likely magnitude of that effect?

DR. HARRISON: Remember now, what they did is, in 2011, you really can't have a private fee-for-service plan in areas where there are networked plans. So, it will change the dynamic quite a bit. Whether they are able to come up with -- I mean, if they come up with networks, then they are really not private fee-for-service anymore so...

MR. HACKBARTH: But this goes back to the previous discussion. They are not, in terms of our existing legal category, statutory categories. But is a plan that basically contracts with everybody using the Medicare rate structure -- just says, well, I'll give you 5 percent more than the Medicare rates if you sign my contract, and it goes to everybody in the community. And because the payment levels are so high, they may have the ability to fund that higher payment level out. So now, they've got everybody in the community funded by taxpayer dollars and higher payments. Are they really any different in terms of their

ability to coordinate care and produce higher value for Medicare beneficiaries and the taxpayers? They are not. They have just taken taxpayer dollars and paid providers more than traditional fee-for-service.

Okay, I think we're done.

We now have our public comment period.

Just as a reminder, the ground rules are please identify yourself and your organization, and limit your comments to no more than two minutes. When the red light comes back on please finish your comments.

Thank you.

MS. CARLSON: Good morning. I'm Eileen Carlson with the American Nurses Association.

These comments are with regards to the hospice benefit. It's very troubling that the discussions regarding length of stay seem to occur without any reference whatsoever to quality of care and patient outcomes. There appears to be an underlying assumption, possibly presumption, that increasing lengths of stay in hospice care necessitate a cutback in hospice benefits and I think that assumption needs to be acknowledged and re-examined.

As recognized by some Commissioners, hospice care

presents a unique circumstance whereby high quality of care can directly result in the lengthening of a patient stay beyond what was anticipated, and this is generally a successful outcome for the patient.

There's also widespread recognition within the health care community of the difficulty, sometimes impossibility, of precisely predicting or projecting how long a terminally ill patient will live.

There's also widespread recognition that hospice care is significantly less costly than acute care and offers many additional benefits for the patient and the family.

Consequently, I would urge MedPAC to include quality of care as an element in examining hospice care length of stay and recognize that a longer stay can demonstrate a successful outcome and a result of high quality of care.

Moreover, the question needs to be examined of whether decreasing payments over length of stay may serve as a disincentive to maintain a high quality of care across a patient's entire length of stay.

Thank you.

MS. KASSON: Hello, I'm Caroline Kasson. I'm the

President and CEO of the National Hospice Work Group and I want to comment on the hospice discussion that we just had.

As a hospice provider CEO since 1981, before there was Medicare reimbursement, I want to first of all thank you for taking up hospice in the intensive and complex way that you have done.

But I wanted to take the opportunity to comment on -- I believe it was Commissioner Butler's -- suggestion that hospice was a social contract with Americans. And I hope that you will continue to explore that. And I hope that you will continue to look at how complicated that contract is in this country, and why some of the other things that were discussed in that comment period still aren't not happening, why hospice is only caring for about 40 percent to 50 percent of the patients, and how misaligned incentives throughout the rest of the health care system really have a great deal to do with some of the issues that you're taking up and continue to look at that.

So I encourage you and I hope you'll work with the provider community to begin to explore some of those things and help you understand, at least from our perspective, how that works.

So I want you to know that we appreciate the work that you've done, that for the most part I believe the providers are very supportive of looking at payment reform. They are extremely supportive, the hospices that I work with on a daily basis, are extremely interested in accountability and very, very eager to ensure that all hospices have high accountability standards.

We are also happy that we're going to get more data that will help you and all of us understand the work that goes on at the patient's bedside.

As you do your work, I think the most interesting thing about perhaps what you do and what we do is that this is the one system that you will take a personal interest in over the next 20 or 30 or 40 years, because you are creating the system that you and your loved ones will be a part of.

So thank you very much.

MS. WILBUR: Hi, I'm Valerie Wilber with the National Health Policy Group and the Special Needs Plan Alliance. I want to follow up on a comment that was made by one of the Commissioners about the exclusion of SNPs and some other models from this analysis.

I think it's really important that SNPs, PACE, and

other programs that potentially are going to be affected by changes in payment system are taken into account, and I haven't heard anything about SNPs or PACE or private fee-for-service being excluded from the type of changes that Congress has looked at when they've talked about going back to 100 percent fee-for-service.

So I understand the reason for excluding it in this analysis, because they aren't universally available. But certainly for special needs plans they are widely available across the country and I would encourage MedPAC to see if they could include them in the analysis.

The other thing I would like to follow up on is I really agree with the widespread support for looking at types of plans in terms of delivery systems and the type of benefits offered and such. Special needs plans have a whole new set of requirements, as you know, under MIPPA which include a wide range of additional care management requirements in terms of having individualized care plans, annual assessments of functional, psychosocial, health risk and individualized care plans for everybody enrolled in the plan.

So I think the fact that SNPs have to develop

these models of care when they submit their application gives a lot of information to CMS about the types of models of care that are being developed that would provide sort of a database for being able to look at these models of care in relation to outcomes and then looking at them in relation to the payment systems being suggested.

And then the last thing I would suggest is, in addition to looking at types of plan and models of care, that you look at patient populations being served by these programs in terms on the adequacy of the current payment mechanism because there have been a number of studies published or underway by groups such as the University of Rochester in New York, Millaman has done work, Redden and Anderson has done work, and Hopkins is about to publish a study that indicates that certain populations, whether it's new enrollees, people with frailty, people with multiple comorbidities, and plans that serve exclusively populations that have sustained high cost over long periods of time are underpaid in relation to fee-for-service by the current HCC system.

So rather than having sort of a blanket across-the-board reduction of MA plans in relation to

fee-for-service, I think it's really important for MedPAC to spend some time looking at which populations served exclusively by some of these alternative plans may currently be being paid less than regular MA plans as you think about how to adjust payment.

Thank you very much.

MR. HACKBARTH: Okay, we're adjourned. Thank you.

[Whereupon, at 12:03 p.m., the meeting was adjourned.]