MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 14, 2010
9:36 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
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NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Take your seats please. I'd like to welcome our guests. As I think everybody knows, today we will be voting on recommendations for our March report to Congress. Today we will review recommendations for nine different types of Medicare providers. In addition, our March report will include some past recommendations that we think are of particular importance, for example, recommendations that affect the distribution of payments among providers, and those recommendations will not be re-voted on but will be highlighted in the text of our March report.

The March report will also include material on Medicare Advantage and Part D, but the way the payments systems work in those sectors, annual updates are not required, so we are not voting on update recommendations there.

As I did in December, I'd like to remind people in the audience that MedPAC's task for our March report is to make recommendations on the Medicare program as it exists today. As such, the context for our work, the context for the recommendations that we're making, is different than

what Congress is doing currently on health reform. And so trying to compare MedPAC recommendations that we vote on today with comparable provisions in the health reform legislation can be misleading. Congress is voting on changes in Medicare in the context of moving towards universal coverage, and that is a materially different context and can influence the content of the decisions.

A notable example of that is that the hospital industry, for example, has been very clear in saying they view Medicare updates differently in the context of universal coverage than in the context of the current insurance system.

We are missing one Commissioner today, Mike Chernew, who couldn't be here due to a death in his family.

As usual, we will have a public comment period at the end of each session. As always, I'd like to remind people in the audience that that is one opportunity to make comments to the Commission, but it certainly isn't the only one or even the best one, in my view. The MedPAC staff make extraordinary efforts to reach out to get input from people affected by the Medicare program, and you should know that the staff prepare a fairly detailed summary of the input

that we receive from various provider organizations for the Commissioners that they can review in advance of their votes on these issues. In addition, we have a feature on our website, Medpac.gov, where people can on the website offer comments on our work.

So with those introductory comments, let's move on to our first session today, which is assessing payment adequacy for inpatient and outpatient hospital services.

DR. STENSLAND: Good morning. We are going to talk about two hospital issues this morning. The first topic is the update recommendation for hospitals. Second, we will discuss the budget neutrality adjustment to offset the increased payments associated with documentation and coding improvements. We'll present a glide path to make the counterbalancing payment reductions more gradual.

We will not be discussing IME at this meeting. As several of you suggested in December, we'll defer the discussion of IME until we have our broader discussion of graduate medical education during future meetings.

First, let's discuss the update recommendation. The update recommendation will apply to hospital inpatient and hospital outpatient payments which make up 92 percent of

hospital revenues. The update will affect approximately 3,400 hospitals that had over 10 million Medicare fee-for-service admissions in 2008 and almost 70 million outpatient claims.

Recall there are many payment adequacy indicators. After reviewing the data associated with all five indicators, the Commission's judgment call as to what the appropriate update will be is made. And these are the same indicators we'll use for the other sectors as we go through their updates later today.

Last month, we discussed how hospital capacity is growing. We see an increase in the number of hospitals, and last year even a slight uptick in the number of hospital beds. Outpatient volumes are increasing and quality of care is improving. Access to capital, however, has been volatile. The capital markets froze at the end of 2008, but now they're starting to return to normal. While these first four indicators are generally positive signs of payment adequacy, profit margins have been low, and they're expected to remain negative.

Here we show the combined inpatient and outpatient margin was -6.4 percent in 2008. When we add in the other

hospital service lines to create an overall Medicare margin, the hospitals' margin was -7.2 percent, and we emphasize this is overall hospital margins, overall hospital Medicare margin.

The first point is that we see a similar trend and a similar level of margins whether we look at the hospitals' inpatient and outpatient service lines or if we look at the hospitals' overall book of Medicare business, including the hospital SNFs and other service lines. In general, the difference between the top line and the second line is one percentage point or less.

Now, we focused on the overall Medicare margin because it eliminates concerns regarding how the allocation of costs among departments and how one service line, such as a hospital-based SNF, can help the profitability of other service lines such as the acute inpatient services. However, looking past 2008, if we go to examine our projections, we expect overall margins to improve slightly due to a belief that cost growth slowed in 2009 but, despite this improvement in cost growth, our overall projection for 2009 is still negative, at -5.9 percent overall Medicare margin in 2010.

Now, of course, there is a certain amount of uncertainty regarding this 2010 projection because we can never be certain about the future of patient case mix or the future of cost growth.

The prior slide reported on the aggregate Medicare margins for the whole hospital industry. However, you have shown a strong interest in our analysis of relatively efficient providers. As you know, we're required to not only look at the average provider, but also look at relatively efficient hospitals. In this slide, we compare the performance of 218 hospitals that we found to be relatively efficient using the criteria we talked about last month to a sample of 1,991 comparison hospitals. The relatively efficient hospitals tended to perform better on several metrics. Their mortality was 5 percent below the national median, their readmission rate was 5 percent below the national median, and their standardized costs were 9 percent below the national median. The lower cost allowed them to break even on Medicare patients. The point of this slide is to show that it is possible to deliver high-quality care at a cost that is covered by Medicare fee-for-service rates.

Given the data presented and your discussions over the past month, the Commission's draft recommendation now read as follows: "that Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program."

The current forecast for the hospital market basket is 2.4 percent; however, this forecast will be updated twice before CMS actually sets the payment rates for 2011. There are no spending implications for this recommendation as it is consistent with current law. We do not see any significant impacts with respect to beneficiaries' access to care. However, there is potential for improved quality of care being generated from the incentive payment program.

Now we'll shift to Julian talking about the glide path for achieving budget neutrality with respect to the transition to MS-DRGs.

MR. PETTENGILL: Good morning. I'm going to start with the budget neutrality adjustments that are required in current law to offset the effects of hospitals'

documentation and coding improvements, and then I'll present the Commission's draft recommendation, which would smooth the required payment adjustments out over a transition period.

As we discussed at the December meeting, here is the background: Following a MedPAC recommendation, CMS adopted MS-DRGs in 2008. The policy goal was to improve payment accuracy and thereby reduce the gains that hospitals could achieve by engaging in patient selection.

The MS-DRGs substantially changed the way cases are grouped for payment. Cases with very costly major complications or comorbidities are grouped separately, and CMS also extensively changed the lists of secondary diagnoses that qualify as complications or comorbidities.

These changes created incentives for hospitals to improve their documentation and coding of secondary diagnoses because hospitals would receive higher payments if cases with complications or comorbidities were reported accurately.

The documentation and coding improvements, or DCI, shifted cases from relatively lower severity and cost MS-DRGs to higher severity and cost groups and thereby

increased measured case mix and payments.

We expect and encourage hospitals to improve their documentation and coding, and the hospital industry has recognized the need to make these improvements to fully capture the revenue available under the MS-DRG system. Still, Medicare's payments should not increase because there has been no real change in patient complexity or in treatment costs.

To counterbalance the higher payments, current law requires large, disruptive payment adjustments. So the issue is not whether to make budget neutrality adjustments but how to make them in a way that smooths them out and makes them more manageable for hospitals, while still achieving true budget neutrality.

Now, I want to remind you of the legislative history behind the current law budget neutrality adjustments.

Based on past experience, CMS actuaries estimated that DCI would be essentially complete by the end of 2009 and that it would increase inpatient payments by 4.8 percent. To offset the expected increase in payments and preserve budget neutrality as required by law, CMS said that

it would reduce inpatient payments by 4.8 percent over three years.

The hospital industry argued that this estimate was too high, and Congress responded and the current law now reflects the following agreement:

CMS would prospectively lower the base payment rates by 1.5 percent over two years; that is 0.6 percent in 2008 followed by an additional 0.9 percent in 2009.

However, if 1.5 percent turned out to be too little based on actual data, two things would happen: First, CMS would change the base rates in 2010, 2011, and/or 2012 to recover the difference in payments, with interest. Second, CMS would also adjust the base rates to prevent further overpayments from continuing. The next slide summarizes the size and timing of the required adjustments.

To determine the size of the budget neutrality adjustments required under current law, we need to know how large the overpayments were in 2008 and in 2009. We know that DCI resulted in overpayments of about 1.9 percent in 2008. We don't know yet what happened in 2009. But to determine the potential size of the required budget neutrality adjustments, we are assuming that the CMS

actuaries' projection of 4.8 percent DCI is correct. Of course, the actual outcome could be different.

We also know that CMS decided not to make a DCI adjustment in 2010 to either recover overpayments or to prevent further overpayments going forward. That means that the required adjustments must be made in 2011 and 2012. It also means that overpayments are continuing during 2010.

Without going through all the details, the conclusion is that in 2011 or 2012 CMS must make a temporary adjustment to recover the 2008 and 2009 overpayments, and in addition to that, they must make an adjustment to prevent future overpayments.

We are assuming that the actuaries' projection is correct and that CMS would split the recovery of the overpayments equally over 2011 and 2012. If that is the case, the total adjustment required in 2011 would be 5.9 percent and it would remain in place for 2012.

In 2013, the base payment rates would rise by 2.6 percent as the temporary recovery adjustment expires. By the way, although we are not showing the details, we have a slide for that if anyone wants to see it.

These adjustments result in two problems. First,

under the draft update recommendation of 2.4 percent, we would expect to see IPPS payment rates fall by 3.5 percent in 2011. Under current law, hospitals would get the full updates in following years, plus the 2.6 percent bump up in 2013. The second problem is that current law would not fully restore budget neutrality because the overpayments during 2010 would not be recovered. The next slide lays out an alternative to current law.

DR. MARK MILLER: Julian, can I catch you just for one second? You've said twice that we are assuming that the actuaries' estimate is correct, but I also just want to reinforce for the Commissioners and the rest of the people in the room, we -- and by that, I mean you guys -- have gone through this and independently done your own estimates and come to the same place. Is that correct?

MR. PETTENGILL: That's correct.

DR. MARK MILLER: Okay. Thanks.

MR. PETTENGILL: The adjustments required under current law are very large, and many hospitals may not be able to easily manage substantial payment reductions even if they're of short duration. So we thought it might be desirable to develop an alternative schedule of adjustments.

The guiding principle here is to preserve budget neutrality, but do it in a way that is manageable for hospitals.

Budget neutrality could be restored by following different paths that trade off the size of the payment reductions against how long they persist. One path would reduce the base payment rates by 2 percent each year for three years, beginning in 2011. If the CMS actuaries' projection of 4.8 percent is correct, overpayments would be fully recovered in 2015. In 2016, the temporary recovery adjustment would end, and the payment rates would increase by 2.7 percentage points above the annual update for that year.

Compared with current law, this policy would provide a series of smaller predictable adjustments over a longer period, making them more manageable for hospitals. Under the draft update recommendation, payment rates would increase by 0.4 percent in 2011. Payment increases in the next two years would equal the full market basket update minus two percentage points.

The downside of this policy is that overpayments would continue to accumulate through 2011, which would add to the amount that would need to be recovered and thereby

lengthen the time needed to restore budget neutrality. The upside is that budget neutrality would be restored, adjustments would be more manageable for hospitals, and the payment rates would still increase somewhat each year as long as the update was greater than 2 percent.

Of course, if actual DCI in 2009 turns out to be lower than 4.8 percent, it might be a good idea to give CMS the flexibility to achieve budget neutrality over the same time period with smaller adjustments in 2011, 2012, and 2013. If actual DCI turns out to be higher, the adjustments would still be limited to 2 percent each year, but the time period would be extended beyond 2015.

With these thoughts in mind, the Commissioners' draft recommendation is as follows: "To restore budget neutrality, the Congress should require the Secretary to fully offset increases in inpatient payments due to hospitals' documentation and coding improvements. To accomplish this, the Secretary must reduce payment rates in the inpatient prospective payment system by the same percentage (not to exceed 2 percentage points) each year in 2011, 2012, and 2013. The lower rates would remain in place until overpayments are fully recovered."

In the accompanying text, we would describe how this policy would play out and how long it would take to achieve budget neutrality. As I mentioned, prevention and recovery together could take as much as 5 years, but we won't know exactly how long it will take until we have the 2009 data. Note also that we are assuming that the recoveries would include accumulated interest, which is consistent with current law. This recommendation would increase spending more than $2 billion over one year, and it would reduce spending from $1 to $5 billion over 5 years.

The recommendation has no major direct implications for beneficiaries. It would improve the stability of the IPPS payment rates over time and make the burden of compensating for the effects of DCI predictable and more manageable for providers.

This concludes our presentation. We'd be happy to take your questions and comments.

MR. HACKBARTH: Julian, I just want to go through the payment adjustments for the DCI again just a little bit more to make sure that I've got it correct and that the audience understands it.

In fiscal year 2011, the rates would be adjusted

downward up to 2 percent but no more than 2 percent. Hospitals would be eligible to receive the market basket, which would tend to increase the base rates. Based on current estimates of the case mix adjustment and the market basket, there would be a small net increase in the hospital base rate. In 2012, again, there would be a 2-percent downward adjustment. That's not cumulative. It's just that the rates would be adjusted 2 percent lower. Same for 2013.

Now, here is the point I wanted to zero in on. In 2014 and 2015, there would be no adjustment for a case mix change.

MR. PETTENGILL: That's correct.

MR. HACKBARTH: And so the rates would be -- there would be zero adjustment in 2014 and 2015, and then in 2016, there would be an upward adjustment reflecting the fact that the collection of the past overpayments is complete, and those are temporary adjustments, and so the rates would increase by about 2.7 percent based on current estimates. Is that correct?

MR. PETTENGILL: That's correct.

DR. MARK MILLER: And I just want --

MR. PETTENGILL: Go ahead.

DR. MARK MILLER: To be clear, though, in 2014, 2015, and then 2016 when the bump-up occurs, the zeroes that he was referring to -- and I know you know this. I just want to make sure everybody knows this. The zeroes he's referring to are the DCI adjustments. There would still be updates in those years, and then in that last year, the 2.7, or whatever number you said, is -- and you said this very clearly -- in addition to the update.

MR. PETTENGILL: That's right.

DR. STENSLAND: Just one other point. The way it's worded is there is some flexibility for the Secretary depending on what the actual data turn out to be. For example, if they find that the DCI is lower than their current estimates, they might not have to stretch it out that full '14 and '15. It might be able to stop is sooner. Or if they find out the DCI was higher than their estimates when they actually look at the data, it might stretch out a little farther. So what's firm is that they have to come to budget neutrality in the end. Exactly how long it takes to get there, there might be a little play, shorter or longer, depending on the actual data that they find.

DR. MARK MILLER: [off microphone] -- the nature

of the recommendation is however they're doing it that it's not to exceed 2 percent in any year.

MR. HACKBARTH: Okay. Let's have hands for clarifying questions. We will start over here.

MR. BUTLER: So really our net recommendation when you take into account the 2.4 estimated market basket and then you have the 2 percent, which is a reduction in payment per se, it's a change in coding. But then we are also reminding us that we're taking out a percent of the market basket to save for pay-for-performance, quality. So really the base recommendation is really 1.4 increase in market basket and then an additional 1 percent to be paid out in -- I'm just reminding what we've said, we're holding out a percent -- that's our recommendation, to -- it stays in the system, but it is tied to value-based purchasing.

MR. HACKBARTH: You are correct. So the guaranteed update for an individual hospital would be the full market basket minus the set-aside for pay-for-performance. An individual hospital based on their performance --

MR. BUTLER: They might get 2 percent.

MR. HACKBARTH: They could get all of that or even

more than that.

MR. BUTLER: Right. Okay. So --

DR. STENSLAND: One clarifying point. The 2.4 percent we're talking about applies to all the inpatient and outpatient payments, and this budget neutrality adjustment is just on the inpatient side. So there's a difference between the inpatient and outpatient here.

MR. BUTLER: Right. Good point. So my other question, which is just curiosity around -- we don't talk much about the components of the market basket update here and don't need to get in a lot of detail, but is it somebody who sits there and budgets for our institution and you look at the supply and drug in particular, not the labor piece, but -- and, you know, you look at what drug companies reportedly are doing, and we see it, you know, getting the prices up in advance of health reform and the day-to-day battles with the device companies that certainly don't come forward and say 2 percent next year.

I'm just curious on that component of the market basket update, how you look at that, particularly in a year like this.

MR. LISK: We have to look at what -- I don't know

exactly what those numbers were in the current forecast. I can get back to you on that. But basically it's all a share of what total costs are within the hospital, and those are integrated in there. And what's anticipated to happen in 2011 may be different than what happened currently in terms of adjustments that hospitals are making -- that the industry might be making to health reform, too. But it's all in there as a share of your cost in terms of what's in there, and sometimes those have been high and have been a contributor to higher market baskets, but it all depends.

DR. CASTELLANOS: Getting back to the recommendation -- and I agree with Recommendation 1 -- I really appreciate we're looking at an efficiency factor on all the Medicare providers. And you talk about a quality incentive program which is pay-for-performance. I wonder where we stand on that and what are we doing with that, just briefly. I hear you talking about it, but I don't see any details of it.

MR. HACKBARTH: It is one of the issues that Congress is trying to resolve in the health reform legislation. The Senate bill provides for a hospital value-based purchasing program. As I recall, the House bill does

not, and so it's an issue that they're trying to reconcile as we speak.

DR. CASTELLANOS: I guess my question is what is MedPAC recommending on that. Or are we just waiting for Congress to come through?

MR. HACKBARTH: We have been recommending a move towards what we referred to as pay-for-performance and what the Senate refers to as value-based purchasing for at least four or five years. And we have recommended that the program be budget neutral, be funded with a reduction in the base rates, and then the dollars be redistributed based on performance.

DR. CASTELLANOS: And that will be in the chapter?

MR. HACKBARTH: Yes. In fact, that's Recommendation 1, the last phrase, "concurrent" --

DR. CASTELLANOS: And that will be --

MR. HACKBARTH: Yes, and it will be explained in the text of the chapter.

DR. MILSTEIN: One of the topics not addressed -- and maybe you can just refresh my memory on this -- is the fate of what is ordinarily a productivity adjustment expected of all industry sectors that we pay. What happened

to that? Why isn't that part of our recommendation? How did that get dropped out?

MR. HACKBARTH: That's a question for me, not for them, and it relates to what we were just discussing with Ron. The Commission has recommended for at least several years now the combination of full market basket concurrent with the introduction of a pay-for-performance program funded, as I just said to Ron, on a budget-neutral basis. And some Commissioners, I think including yourself, have for several years now advocated for productivity adjustments for hospitals notwithstanding the fact that hospital Medicare margins have been negative and declining; whereas, other Commissioners have been concerned about the negative margins and believe that that justified a full market basket increase.

And so the compromise, if you will, that we have come to for the last several years is full market basket, but in the context, in conjunction with movement towards a pay-for-performance program. And as I said in response to either Ron or Peter, one of the implications of that is that the guaranteed update is less than full market basket, which is a point that I've emphasized numerous times in

congressional testimony when people say you're simply recommending full market basket.

I know when we first worked through this -- and it wasn't easy to try to forge this compromise -- there were a number of Commissioners -- and you may have been one of them, Arnie -- who said, "I won't vote for a full market basket recommendation unless it's concurrent with pay-for-performance." So some people -- and I won't put these words in your mouth, but some people saw this combination of full market basket with pay-for-performance saying, "We're willing to do full market basket to help grease the skids for movement towards pay-for-performance, but we're not willing to give guaranteed full market basket updates for everybody. We want them to earn that based on some performance."

Like any agreement of this sort, it is not perfect in everybody's eyes, but it has been the consensus of the Commission now for several years.

DR. BERENSON: This is for Julian. I understood the whole explanation of what you laid out except the 2.7 percent one-time bump that occurs. Where does that come from? And can't we in a sense spend that earlier to reduce

the magnitude of the earlier year reductions?

MR. PETTENGILL: The 2.7 percent comes from the expiration of the temporary adjustments needed to recover the overpayments. So you are reducing payments to accomplish two things. The first one is to stop the bleeding, in effect, by preventing further overpayments from occurring. But then after that, you're also reducing the payments some more in order to recover the overpayments that have already occurred and are, in fact, now occurring.

And so when you come to the end of that, that's temporary, and you get the bump-up in the rates. And I don't think there's anyway that you can smooth that out.

MR. HACKBARTH: Other clarifying questions?

MS. BEHROOZI: I think it's sort of related to Bob's question. Did I hear you say that the two percentage points in each of 2011, 2012, and 2013 are not cumulative, it is just two percentage -- whatever it would have been, it is going to be --

MR. HACKBARTH: Yeah, they are not cumulative, so the rates, the base rates, whatever they would be in 2011, are adjusted downward by 2 percent. In 2012, it's 2 percent. It's not cumulative. It's not 2 plus 2. It's 2

percent below what it would otherwise be. Then the same in 2013.

MS. BEHROOZI: I'm having a conceptual problem. I'm sorry. I see how that could achieve recoupment of an absolute dollar amount, but I don't see how it adjusts going forward. I'm missing that.

DR. MARK MILLER: Okay. This is what I would say, Jeff, based on conversations you and I have had. Okay? One way you can think about current law is you basically have to get six points kind of immediately, if you follow the current law construct. This is in a sense ticking two points at a time to that point, then holding it; and although updates are occurring -- I just want to keep reinforcing that -- and then you get the bump-up that Bob said.

So I'm not exactly sure what you guys are saying to each other, but it's down 2, then down 2, then down 2 again. Jeff?

DR. STENSLAND: Maybe you could think about it, to simplify things, imagine that we had a 2.4-percent market basket every year and they got a full market basket every year, just to make things simple. Then you would take this

2 percent off of that every year, so their inpatient payments, rather than going up 2.4 percent for those three years, would go up 0.4 percent this year, 0.4 percent the next year, and 0.4 percent the next year.

MS. BEHROOZI: And then that's how the cumulative effect is realized.

PARTICIPANT: The base is [off microphone].

MS. BEHROOZI: On the rate, yeah. Okay. Thanks.

MR. GEORGE MILLER: Just a quick question on the top performers. That is on Slide 7. That margin is 0.2 percent and that is the median, so that means even the top performing hospitals had negative margins. Some of them had negative margins as well. Can you give me the distribution of those? Or is it just mathematical --

DR. STENSLAND: It's going to be about half of them are making some money on Medicare, half of them aren't making money on Medicare, and part of the reason for that is we've said in other meetings that the Medicare payment system isn't perfect. You know, we think there are some issues with the wage index which might send too much money to some place and not enough to another. There are other issues with the IME payments; you know, if you get a lot of

IME and DSH payments, you're more likely to be making money than other hospitals. So that explains why some of them might be on the winning side and some might be on the losing side.

MR. GEORGE MILLER: But we highlight these efficient performers, and we want other hospitals to be like them. Am I correct in following that? So I was just struck by that.

And then do we know if those efficient hospitals have the other services like a SNF and/or home care, our earlier discussion about Medicare margins for those entities and how they impact it?

DR. STENSLAND: They do, but I'd have to make a run of that to see what share of them have SNF and home health and those kinds of services. Certainly some of them do.

MR. GEORGE MILLER: Okay. Very good. Thank you.

MR. HACKBARTH: Other clarifying questions?

DR. DEAN: Just to follow up on that same issue -- and I don't know whether this is round one or round two, but that group, which, of course, is a relatively small group and actually is a smaller group, I think, than you reported

before, but I think your criteria were a little more stringent this time around. Is that true? But I'm curious, and maybe it's way too early to know, but is that a stable group or are there hospitals moving in and out of that group? And I guess the basis for the question is obviously our intent would be to try and figure out incentives that would draw hospitals into that group, and my concern at least would be to know, to try to pin down -- I know we've talked about this before, and it's still a little nebulous as to what the basic factors are that get hospitals into that group. But I guess we need to -- it would be helpful to know is it a constant group. Are there hospitals moving in and out? And are we making any progress to determine what leads hospitals to do that?

DR. STENSLAND: There is probably from last year to this year -- I don't remember the exact number, but something on the order of 60 to 70 percent of the hospitals in that group are the same, and there could be a couple of things that drive the change. One thing that might drive the change is we did change the criteria because this year we have more data on readmissions, and so readmissions plays a bigger weight this year, so the hospitals, to get in that

group, it's a little more stringent on who gets in on readmission criteria. And then also there is a change in administration, and we've seen that in some of the hospitals we visited, that if the administration changes and the objectives of the administration change, sometimes the performance of the hospital can change. So there will always be some movement in and out of there.

MR. HACKBARTH: Jeff, as I recall, another change in the criteria was that we looked at Medicare expenditures per capita, per beneficiary, and excluded hospitals that were low on inpatient costs but the total expenditures were high. Is that correct?

DR. STENSLAND: The two other criteria that we put in, one is we eliminated anybody that was -- the 10 percent of hospitals that were in counties with the highest per capita spending because we didn't want people to have low per unit costs just by having lots of units.

MR. HACKBARTH: This was the suggestion that Arnie had made.

DR. STENSLAND: And then the other thing that we did is there's been some criticism of others of some analysis like this of saying, Well, the way you get low cost

and good outcomes is you only treat high-income folks. And what we also did is then, okay, just to be conservative, we eliminated everybody in terms of the 10 percent of hospitals that had the lowest Medicaid shares. So basically all the hospitals that are in this group are also serving Medicaid patients. So we're trying to get to that point of can you have good outcomes at a low cost while serving a broad spectrum of the community, including Medicaid folks.

DR. MARK MILLER: Just in case this is not clear, as each year we arrive and show you this group of hospitals, it can be that membership has changed. But the criteria to be in this group at any point in time is that you've performed with these characteristics for three years running. So it's not, you know, in and out from year to year. We're looking at a group of people -- and this is somewhat stringent -- and saying you have to be consistently looking this way in order to get into this group.

MR. GEORGE MILLER: Excuse me, Mark. I apologize. But that could mean, though, that half of that group for three years could have negative Medicare margins.

DR. MARK MILLER: I wanted to say something about that, but I didn't want to be argumentative, but since you

brought it up again.

[Laughter.]

DR. MARK MILLER: Another way to look at this -- and this goes in part also to Tom's question about what incentives, and there are two incentives, I think, that are in play here that we're trying to push. Number one is the pay-for-performance and getting some of the payments to move on quality because then you want to move into that group because then your payments would go up. But the other one -- and this is the more, you know, unhappy one -- is this broader sense of fiscal pressure on controlling cost. One response to the median point is, well, look, some of those people have negative margins. Absolutely. But the other way to look at the entire cost distribution is that if there's a lack of fiscal pressure -- and we've been making this argument that broadly there is -- the whole cost distribution is kind of sitting potentially in the wrong place, moved to the right as opposed to what we're trying to do is push it more to the left.

And so you're absolutely right, and that was a very astute comment on the 50 percent at the median. But the other argument is the underlying distribution of cost

has not had a lot of pressure on it for the last several years.

MR. HACKBARTH: Let me --

MR. GEORGE MILLER: Not to debate you at all --

DR. MARK MILLER: [off microphone].

[Laughter.]

MR. GEORGE MILLER: But you have inefficient, poor quality, making much higher margins, so I'm trying to understand --

MR. HACKBARTH: Who are you referring to there, George, as the inefficient, poor-quality group? Have you identified -- what are your criteria for that? We've identified our criteria for the efficient --

MR. GEORGE MILLER: I haven't yet. I'm just taking the --

MR. HACKBARTH: Okay, so this is --

MR. GEORGE MILLER: -- opposite of his argument that I think that there are some folks that may have -- it's a case mix issue. And I don't know how to drive them -- I mean, your goal is to drive more hospitals like the efficient providers by definition.

MR. HACKBARTH: Right.

MR. GEORGE MILLER: But there are some that may not have the greatest quality, but they're making a higher margin because of case mix, and only because of case mix.

MR. HACKBARTH: Yeah, well, two dimensions --

MR. GEORGE MILLER: You're not going to penalize them by --

MR. HACKBARTH: Well, a few dimensions to this. One, if they're achieving their higher margin through poor quality, skimping on care, that's one of the reasons we believe that pay-for-performance is important.

DR. MARK MILLER: It would be.

MR. HACKBARTH: And it would redistribute money away from those institutions towards the higher-quality institutions.

I do want to do a quick round two, but one last clarifying question. The spending implication for Recommendation 2 -- and maybe I missed this, Julian, when you went through it. So it increases spending by more than $2 billion over one year, and that's because we're reducing the case mix, the DCI reduction relative to current law, which you explained would be 5.9 percent.

MR. PETTENGILL: That's right. It's 2 percent

instead of 5.9, and so we'd spend more.

MR. HACKBARTH: Yeah. And then reduces spending by $1 to $5 billion over five years. Now, is that a reference to the combination of Recommendations 1 and 2?

MR. PETTENGILL: No.

MR. HACKBARTH: Or is that just 2 --

MR. PETTENGILL: That's just 2.

MR. HACKBARTH: That's the piece that I didn't --

MR. PETTENGILL: And the reason for that is that current law would not recover the overpayments that are occurring in 2010 and 2011; whereas, Recommendation 2 would recover them.

MR. HACKBARTH: Yes, okay. Got it. Thanks.

Okay. Hands for round two comments?

MR. BUTLER: Okay. One quick comment on the productivity issue. Remember that if you were to take our collective recommendations -- not recommendations but work that relate to things like readmissions, bundling, and so forth and look at the potential savings there, as is being done in health reform, and look at the collective payments to hospitals, you'd be getting a lot less than the full market basket that you would be paying for hospital care

because you're getting savings from another side of the equation, which is a little different than we're looking at updates in other areas.

I would say I'd like to see us look at, one thing in the future to keep our eyes on, and that's IT for a lot of ways going forward. The stimulus rules are out there. The budgets are ramping up in this area. And it's not just the operating expense. It's the capital expense. And I think we really should think about -- because as the stimulus dollars come in, assuming they do, they come through -- and they're not small -- on the operating side, yet they're often going to be spent on the capital side. And how this is all playing out is, I think, by itself invites a rigorous examination of how hospitals are responding, behaving, and using this in terms of a very, an extremely important lever in our agenda. I'd just encourage us to kind of really understand both the financial pieces of this going forward and its impact on the bottom line as well as how it's helping, or maybe not as much as we'd like in some of the rest of our agenda.

DR. MILSTEIN: Yeah, I mean, obviously consensus is only reached through compromise, but I sense there will

be a number of editorial comments made along the way. And, you know, as Pete just made one, I'd like to make one as well, and that is the -- maybe I could frame it in terms of Pete's language, that if we're going to study issues such as the one that Pete recommended we study, I think we should also -- I'd like to see a countervailing recommendation that we also study the overall impact of -- what's the word? -- low expectations of an industry having an impact on the industry's performance and long-term productivity growth.

I completely understand the political wisdom of Glenn's response to me, but at the end of the day, if you were to in the private sector say, well, we realize you want better performance from your suppliers, but you're not allowed to ask of your suppliers recovery of overpayments that you tried to block in the first place but the industry overrode you; two, the emphasis on quality and purchasing and a reasonable expectation of productivity growth that is sort of consonant with what's expected of the rest of American society; and essentially say you can't have all three of those as a purchaser, you have to make trade-offs among them. People in the private sector would look at that and be puzzled, this notion that, you know, it's too much to

expect of a generally well paid and rapidly growing industry. It doesn't -- it wouldn't foot in a private sector calculation. I realize we're not in a private sector environment, but, you know, I think I will support the compromise, but my reservations are in some ways, you know, on the complete opposite side of the ledger than the understandable reservations of those whose empathy is more with the industry.

DR. MARK MILLER: Just to put that in context for both the public and for everybody else, what you're speaking to directly is on the DCI recommendation, you would be more inclined to go up front and say, okay, I'm taking out everything prospectively, then do a recapture, so you would have deeper cuts at the beginning or deeper recapture at the beginning.

DR. MILSTEIN: And I would also add an expectation of productivity growth.

DR. MARK MILLER: Oh, from [off microphone].

DR. MILSTEIN: Yes.

DR. MARK MILLER: I see.

DR. MILSTEIN: Both.

MR. BERTKO: I'm just going to express some

support for Recommendation 2 and remind everybody coding adjustments have been recovered in Medicare Advantage plans in much the same way. Glenn, I support your idea that we should do it in an orderly and I will call it moderate fashion, so it seems like an acceptable compromise there.

MR. HACKBARTH: Other comments?

[No response.]

MR. HACKBARTH: Just before we go on, I want to just make a couple comments, one on the issue of case mix and then more broadly related to Arnie's point and George's as well.

On the issue of case mix and how we adjust for that, to me the important principle is that when we change our case mix systems, whether it be for hospitals or for other providers, those changes should be by definition budget-neutral changes. That's a principle that MedPAC has stood for, endorsed consistently across all of Medicare's payment systems.

There's room for reasonable people to disagree about the schedule for making those reductions, and there's no real right answer to that. Depending on your logic, your framework, you can arrive at different readily defensible

conclusions, and obviously the recommendation that I'm offering that Julian described is one that I think is appropriate, reasonable, and readily defensible, and, most importantly, it reemphasizes our conviction, our collective conviction that this ought to be a budget-neutral change in the case mix system.

On the broader issue of how much pressure to apply, like you, Arnie, I believe applying pressure, whether it's to hospitals or any other group of providers, is a critically important thing to do.

In the competitive marketplace that exists for most other goods and services, that pressure comes automatically through competition, and especially in manufactured products, increasingly competition with producers in other countries that have dramatically lower labor costs. And that pressure is relentless, it's unforgiving, and it's cost countless Americans their jobs, their health benefits, their retirement. And you know that story as well as I do.

Those people and the businesses that employ them are the people who pay the taxes that fund the Medicare program, and it seems to me that it ought to be a goal of

the Medicare program to assure that the providers who provide services to Medicare face some of the same relentless pressure to improve their efficiency and productivity.

Now, that doesn't lead you automatically to the right answer for an update for any given sector, whether it's hospitals or physicians or any other. But it does mean that the Congress, who ultimately makes these decisions, needs to be prepared to resist the cries of underpayment, this is not fair, our costs are not covered, all those other firms out in the economy facing competition. It doesn't work. What are your costs? We'll pay a price that covers your costs. That's just not how the economy works. And what we're trying to do is introduce some of that same pressure into Medicare's administered price systems.

It's not easy, and certainly for the Congress, it's a very difficult thing, faced with constituents, people that they know and trust, saying, you know, we're suffering financially because of Medicare payment policies. But it's inherent in running this sort of system, and so not just in the hospital case but across all of the recommendations that we'll be considering today, I think that needs to be a

consistent element, and I personally feel that the package as a whole is consistent with that objective.

So it's time to vote on the hospital recommendations. We have two. Would you put up number 1, please?

Okay. All in favor of Recommendation 1, please raise your hands. Opposed to Recommendation 1? Abstentions? Okay.

Recommendation 2. All in favor of Recommendation 2? And I forgot to raise my hand. I'm voting for both of them. Opposed to Recommendation 2? Abstentions?

MR. HACKBARTH: Okay. Thank you. Good work, guys.

Next up is physicians.

MS. BOCCUTI: Okay. So for this session, Hannah and I are going to review the payment adequacy analysis for the update and then you can discuss the recommendation, and Kevin is going to review some of the items he discussed last month on payment accuracy and equity for physician payments.

So just a bit of background. Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services.

Physicians can provide these services in all settings, so not just physician offices.

In 2008, Medicare spent about $61 billion on fee-for-service physician services, and that counts for about 13 percent of total Medicare spending in 2008.

Among 950,000 practitioners who billed for physician services, physicians accounted for 570,000, about, of them. The other practitioners that are billing Medicare for physician services are limited license practitioners -- those are optometrists, podiatrists, chiropractors, oral surgeons, and others -- and other health professionals who bill are nurse practitioners, physical therapists, and physician assistants.

Almost all fee-for-service Medicare beneficiaries received at least one physician service in a year, so that is about 97 percent in 2008.

So now, Hannah is going to talk about the MedPAC survey.

MS. NEPRASH: As we discussed at the December meeting, results from our 2009 survey indicate that most beneficiaries have reliable access to physician services, with the majority reporting few or no access problems.

However, access to primary care physicians remains a concern.

As in previous years, we continue to find that most Medicare beneficiaries are able to find a new physician and get timely appointments when needed. Medicare beneficiaries report better access on these indicators than privately insured individuals. For example, among survey respondents seeking an appointment for routine care, 77 percent of Medicare beneficiaries and 71 percent of privately insured individuals reported that they never experienced delays finding that appointment.

When we asked about the ease of finding a new physician, we heard that most people are not looking for one. Only six percent of Medicare beneficiaries and eight percent of privately insured individuals reported that they had looked for a new primary care physician in the past year. However, among those who did look for a new physician, finding a new PCP was more difficult than finding a specialist.

This year, we also oversampled minority individuals and analyzed the survey results by race. We find that all minorities surveyed experienced more problems

finding a new physician and getting timely appointments. For example, minorities in both insurance categories were more likely to report always experiencing routine appointment delays. We observed roughly a four percentage point differential between white and minority respondents in both insurance categories. Minorities within Medicare reported better access compared with privately insured minorities.

In response to questions at last month's meeting, we also analyzed these survey results by urban and rural residents. In both urban and rural areas, Medicare beneficiaries reported similar or better access than privately insured individuals. We will continue to track these questions closely in future surveys, but for now, I'll turn it back over to Cristina.

MS. BOCCUTI: This slide summarizes findings on access to physician services from other studies, and I've separated them into the patient studies and physician studies. With regard to the patient studies, we certainly probed some of the same -- or the other studies probed some of the same issues that Hannah just discussed for our survey and findings were similar. I'm not going to review those

because I have last month and they're also in your chapter.

But I do want to follow up on a point that Nancy Kane brought up last month about wait times. Work by HSC has found that wait times have increased, but this is true for both Medicare and for privately insured patients. So it's difficult to pin these wait time increases on Medicare payment. More recent research -- that HSC research is a bit dated -- more recent research that we have, and I think that Nancy pointed us to, does not distinguish between Medicare and private insurance, so it's tricky there.

It's also interesting to note that although wait times are increasing, beneficiaries in our survey and in HSC's survey are showing that the patients are not necessarily complaining about these increases. You know, we ask these same questions about are delays beyond what you expected and they're not going up. So think of that as a concurrent to wait time increases.

Then back to the slide on the focus groups for patients. As we discussed last month in our focus groups, we found that most beneficiaries had longstanding relationships with physicians and they didn't have trouble finding one. However, lower-income patients were more

likely to say that they experienced problems than higher-income patients. Beneficiaries said that they were satisfied with Medicare and some even said that they preferred it to the private insurance that they had previous to Medicare.

And then regarding the physician studies, surveys have also shown that most physicians are accepting Medicare patients, as we also found in our focus groups, and physicians told us that they were accepting some private insurance -- or they accepted -- all the physicians said that they were accepting private insurance, but they didn't accept all private insurance plans, and that, of course, varied by market area.

We also found that there was considerable agreement on their likes and dislikes regarding Medicare. All physicians complained that their payments were low relative to private insurance rates, but they did like the predictability and reliability of Medicare payments and coverage.

I want to take a minute now just to go over one issue on physician access that was raised last month. As you recall, in our focus groups, physicians cited psychiatry

most frequently as being difficult for getting Medicare referrals, and several of you concurred with this point. Two issues are at play here.

The first is that beneficiary cost sharing for these services is quite high. Prior to January 1 of this year, it was 50 percent. Researchers have attributed access problems for Medicare beneficiaries for these outpatient psychiatric services to this high cost sharing. The research has found that psychiatrists may be reluctant to accept Medicare patients who do not have supplemental insurance that fully covers their cost sharing because it can be hard to collect these cost sharing payments from some patients, and also from Medicare and from Medicaid in several States. However, in MIPPA passed a few years ago, Congress enacted legislation to lower this cost sharing. So over the next four years, the cost sharing is going to go down to 20 percent, which will be equal to Part B -- most Part B services.

But note, however, that this MIPPA payment change does not affect the overall payment rate allowed in the fee schedule. So the second issue that could be affecting access to psychiatric services would be the overall fee

schedule rate. Further research on Medicare's payment for these services would be needed to determine if they are undervalued relative to other Medicare services.

Also regarding Medicare fees, our analysis of Medicare fees relative to private insurers shows that averaged across all services and geographic areas, Medicare fees are lower, but the gap, which is around 20 percent, has been generally steady over the last decade.

And to Bob Berenson's question last month, for this analysis, we do compare allowed fees. That includes the insurer payment and the patient's cost sharing, but it doesn't include balance billing. And balance billing, just to say, is very uncommon for Medicare. Among patients and other practitioners billing Medicare, 95 percent of these practitioners agree to accept Medicare rates as payment in full, so they don't have balance billing.

Kevin is going to next review some of the volume components of our analysis.

DR. HAYES: We've been talking about fees, Medicare's fees for physician services, but, of course, physician revenues are influenced also by the number and intensity of services billed. As we see here, the data

through 2008 show that the volume of physician services has continued to grow. However, growth has been somewhat lower for evaluation and management services and major procedures relative to other services, imaging, other procedures, and tests.

Specific to your vote today, volume growth provides context for considering the disparity in recent years between payment updates for physician services and changes in input prices for those services. Under the SGR policy, the update was a minus-five percent in 2002, and since then, as the Congress has overridden the SGR formula, the updates have been fairly modest.

But for the two years before 2002, physician updates exceeded the Medicare Economic Index, a measure of input prices for physician services. So to get a fuller perspective, we compare on this slide the updates and the MEI starting in 1997, the first year of the SGR policy. Still, over this 12-year period, the updates totaled 17 percent while the MEI went up 34 percent.

What's missing in such a comparison, however, is the role of volume growth. Over the same 12 years, Medicare spending for physician services went up by a total of 90

percent. That's growth in spending per beneficiary. Volume growth is what makes up that difference between the updates and spending growth, and it's the combination of volume growth and the updates that determines growth in physician revenues.

Cristina will now continue with our presentation.

MS. BOCCUTI: So this slide, you've seen before. It's on quality and summarizing the quality assessment. This shows that most quality indicators were stable or improved slightly from 2006 to 2008.

So then on to the next slide, has the second part of our adequacy framework. These are changes in costs for 2011. CMS's forecast for input price inflation is 2.1 percent, and their forecast for the MEI, which includes a productivity adjustment, is 0.9 percent. And as always, these forecasts are updated quarterly.

Next slide. So on to the recommendation that you reviewed last month. Given the array of indicators we reviewed in our assessment, which is generally good access, stable quality, increasing volume, and a need to be fiscally disciplined while maintaining access to physicians' services, you discussed a modest update of one percent.

Specifically, the draft recommendation reads, "The Congress should update payments for physician services in 2011 by one percent."

Regarding the implications of this recommendation, the spending effects are, of course, very large because any increase is scored relative to the cuts in current law that are called for by the SGR. So it would increase Medicare spending by more than $2 billion for 2011 and more than $10 billion over five years. Additionally, the update would increase beneficiary cost sharing and would maintain current supply of and access to physicians.

And then this slide here shows the reprinting of a recommendation that you've made in two previous reports. This is the recommendation to emphasize the importance of access to good primary care in a well-functioning delivery system. So we'll be putting this recommendation in the report, and I think it's going to be held in a position that's prominent with the recommendation for the update, and it calls for budget-neutral increases in payment for primary care services provided by practitioners who focus on primary care.

And now, Kevin is just going to finish up with the

work he talked about last month.

DR. HAYES: To close the presentation, we just wanted to give a reminder that while today you are considering the update for physician services, we are also considering distributional issues. In other words, we are looking at how payments are distributed among different types of services in the fee schedule. Recall that at the December meeting, you discussed questions about the accuracy of the fee schedule's estimates of the time physicians spend in furnishing services. For the physician update chapter, there will be an appendix on these issues.

Meanwhile, staff work on the issues is continuing. For example, we have had a discussion of technical issues with the AMA. At future meetings, your deliberations could lead to recommendations, say, on alternative data services for physician time. You could also consider options for improving the valuation process more generally.

That concludes our presentation. We look forward to your discussion.

MR. HACKBARTH: Good job.

Clarifying questions, starting on this side. Jennie, and then George.

MS. HANSEN: Yes, thank you. Thank you for all the added kind of deeper focus groups that were done on beneficiaries, and I can see the access has been relatively good. So this is more of a contemporary press item that came up, I think it was last month, about the Mayo Clinic beginning not to take on new Medicare. So that is beginning just to draw some attention. I wonder if there was any more review of what that might mean or plans to review that.

MS. BOCCUTI: Yes, we did we look into that. I want to say a couple of things about how that worked. First, the clinic is about a five -- at least what they're showing on the website, it's about a five-person, or five-physician family practice clinic. It is in Arizona and there are other physicians affiliated with Mayo that are in Arizona. I think it's over 200. You know, you have other specialists, others. But this is a five-person, five-physician practice.

I want to be clear that what they did specifically is now said that they're going to be charging the patients that want to stay with that practice a fee, an administrative fee, and those physicians have opted out of Medicare, which means that they're entering into a private

contract with their patients. Excuse me. My glasses just broke, so it's a little fuzzy.

But what I want to be clear on is that this is part of a model that we've been looking into regarding retainer-based care or concierge care, which we do see in more affluent communities so that they're able to see patients that are able to come up with the financial resources to pay out of pocket for all their services.

So what this clinic has talked about is that they have -- in addition to the fee that the patients have to pay to be able to stay, and these are for -- they're Medicare patients -- they would also be paying for all the services out of pocket, and their estimate would be if they had their physical and a few office visits, it would be about $1,500 in the year.

So we have been looking into concierge practices or retainer-based care and we can discuss that further if you want more details on this.

MR. GEORGE MILLER: Thank you, and very good work. I really appreciate the information about minorities in the chapter. I'm struck by something the chapter -- and I support the recommendation, but I was struck by something in

the chapter that said that patients attribute problems with referring patients because they were either uninsured or underinsured to specialists and they consider that a barrier because of that reason. Did I misunderstand the chapter? I thought we were only talking about Medicare patients. But is that broad-based patients and all insurances, or just Medicare patients who are having a problem -- physicians that take Medicare patients?

MR. HACKBARTH: What page is that on?

MR. GEORGE MILLER: That's on page ten and 11, the bottom of page ten and the top of page 11, because I thought we were talking about Medicare patients and I said, why would they have a barrier if they had the same insurance? But then it did refer to the fact that they were uninsured or had low insurance, and that was the access barrier, and I was just wondering why.

DR. CASTELLANOS: [Off microphone.] Because they had Medicaid.

MR. GEORGE MILLER: Because they had Medicaid? And if that's the case, then what happens to those patients who don't get specialists to take care of them?

MS. BOCCUTI: Okay. You're referring to the work

by the Center for Studying Health System Change.

MR. GEORGE MILLER: Yes. I'm sorry.

MS. BOCCUTI: And I think in order to show a complete picture, we discuss what their practices or what the patients in their practices are facing.

MR. GEORGE MILLER: So it's not just Medicare patients?

MS. BOCCUTI: Right. As -- I think if I -- right. It talks about their minority patients and then their difficulty --

MR. GEORGE MILLER: Right.

MS. BOCCUTI: -- because when you think about sort of the other work that Hannah has been working on, there are practices that have higher shares of minority patients --

MR. GEORGE MILLER: But they were Medicare patients and they still had an access problem, so when I read this, I was comparing that with the original study and then wondered what happens to those patients if they can't get referred for specialists.

MS. BOCCUTI: Right. It's hard for us to know, really, what happens to them after they leave that office because we're not surveying them.

MR. GEORGE MILLER: Yes.

MS. BOCCUTI: I mean, we do find that in Medicare, they may have some problems, but in most cases, they do find a physician, specialist and primary care, but there may be more phone calls that they have to make.

MR. HACKBARTH: So just reading that entire passage on the bottom of page ten --

MR. GEORGE MILLER: Ten.

MR. HACKBARTH: -- and top of 11, it looks to me like the Center for Studying Health System Change work is on all patients, all minority patients, not Medicare patients only.

MR. GEORGE MILLER: It's just not Medicare. Okay.

MR. HACKBARTH: That's the way I read it.

MR. GEORGE MILLER: But even earlier on, it said that minority Medicare patients had a problem disproportional to white patients to get referral to specialists.

MR. HACKBARTH: Right. Yes. The reasons there would obviously be something different, other than they're uninsured --

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: -- because by definition, they are insured.

Other clarifying questions?

DR. BERENSON: Yes. I wanted to follow up. I was going to ask Jennie's question, also, about that Mayo Clinic article, which I got myself quoted on. I got some quite interesting e-mail related to that.

But I wanted to take the more general point about opt-out. The last I looked a few years ago, there were only a few thousand physicians, and a good portion were psychiatrists, who had opted out. Is that something you are monitoring and do you have current data on that?

MS. BOCCUTI: Well, I called CMS with that exact question, and so far, they've been tracking opt-out. They have to get it from -- these are information that are with each carrier, so they have to get a summarized report from the carriers. And they've been tracking it quarterly, but they haven't really summed it up and they have already started the process of giving summary amounts and get numbers.

The other problem with what they've been collecting is that the numbers are only on new activity, new

opt-outs. So if a physician renews their opt-out status, which they need to do every two years, they're not really capturing that in the data that they have. But they have already started -- and this didn't just happen because of this news item -- they've started, I think, with this quarter, or with this calendar year, to be collecting more data that includes current opt-outs and new opt-outs.

But with the data or the reports that I've read, we're definitely talking about a very small number of physicians. Certainly with the concierge opt-out, we're talking about around a thousand. There are some reports that are higher, some that are lower, around the United States. Now, these are more often in urban areas, more coastal. But they do have a relationship to opt-out. I think they are more likely to be opted out if they are in a concierge practice.

But we have tried to get on top of understanding the number of opt-out physicians and we don't have a really good number for tracking year after year, but just for changes.

DR. BERENSON: And just to follow up on that family practice in Arizona --

MS. BOCCUTI: Right.

DR. BERENSON: -- they have a separate Tax ID number, separate business entities, presumably?

MS. BOCCUTI: I can look into that.

DR. BERENSON: I mean, I'd be interested in how --

MS. BOCCUTI: The other is --

DR. BERENSON: I mean, is the Mayo Clinic the Mayo Clinic or are these just affiliated practices? I mean, I think it's -- it wasn't clear from the reporting.

MS. BOCCUTI: Right.

DR. BERENSON: It's not that urgent a thing, but if you could look into it, that would be great.

MS. BOCCUTI: But you are right about the opt-out being focused in certain specialties, as well, and psychiatry is one of the highest specialties that has opt-out.

DR. MARK MILLER: The other thing is, we have a -- you can't see me --

MS. BOCCUTI: I can hear you.

[Laughter.]

DR. MARK MILLER: All right, don't tell her we're going to make faces, okay?

[Laughter.]

DR. MARK MILLER: We also have a contractor report coming forward on this issue--

MS. BOCCUTI: Right.

DR. MARK MILLER: -- so we may have some more information, but I think you do raise a good point. In conjunction with that report, which you will, as we work through it, eventually see, we ought to think about how we're going to monitor it just some more on this exchange.

So the take-away from the Mayo thing is these physicians, there are still Mayo physicians accepting Medicare, in fact, broadly in Arizona. It's these five who have chosen to opt out, is that right?

MS. BOCCUTI: Right. There's two facilities or Mayo Clinics, main places, and this is just one of them, and it's five of hundreds that are affiliated with Mayo that they've said in their information that cardiologists, all other specialties, it's simply -- it's this family practice clinic that is --

MR. HACKBARTH: So is it all of the family practice physicians affiliated with Mayo in that Medicare, or just one unit?

MS. BOCCUTI: No. It's just this unit.

MR. HACKBARTH: So there are other family practice physicians affiliated with Mayo in Arizona that continue to participate in Medicare?

MS. BOCCUTI: That's true in Arizona, but they would be with a different clinic in Arizona. So they have two --

MR. HACKBARTH: But they still have Mayo.

MS. BOCCUTI: There's like a Scottsdale -- right.

MR. HACKBARTH: Right, yes.

MS. BOCCUTI: So in Arizona, but in a different town.

DR. MARK MILLER: [Off microphone.] Thank you.

DR. KANE: It seems like we need a little misinformation media function somewhere.

On Slide 11, I just kind of had a disconnect between the relationship between the input price inflation and the MEI. So I don't understand how we get from 2.1 to 0.9, because isn't it the MEI that we're using to measure inflation and the --

MS. BOCCUTI: The input price inflation is not adjusted for productivity.

DR. KANE: Oh, okay. So that's --

MS. BOCCUTI: When you have a productivity adjustment, which is what the MEI is, that includes a productivity adjustment and it comes to 0.9 percent.

DR. KANE: Okay. So --

MR. HACKBARTH: I had the same question about the slide that Kevin went through on nine. It lists -- this is MEI. Does it mean literally MEI with the productivity adjustment as opposed to just the input price? Okay.

DR. KANE: Okay. Thanks.

DR. CASTELLANOS: Just a couple of clarifications. I am going to have a lot more comments in round two. One is the time estimates. I just hope that we have the opportunity to discuss this. Bob, I know you have done some work on that because I've been reading. I looked at the MGMA study that was quoted last time and I think we need to look at that a little bit more carefully. And there's a Cromwell thing that was -- a gentleman that was quoted, too, and we have to look at that more carefully. So my clarification point is, before we put it in the text, I would hope that we could have the opportunity to discuss it a little more.

The second point, and again, it's really commenting on some of the points that were made up about opting out, you know, one of the things I read in Part A in the material that was sent around is 92 percent of the primary cares participate in Medicare. So there's eight percent of the primary cares that have opted out. Those 92 percent that participate, only 73 percent accept Medicare.

DR. MARK MILLER: [Off microphone.] Where are you looking?

DR. CASTELLANOS: Part A data, the material that was sent to us in Part A in the material -- Tab A, excuse me. Tab A. I was surprised, and I can show you those articles.

DR. MARK MILLER: [Off microphone.] We will look at it.

DR. CASTELLANOS: Okay. the other point about the Mayo Clinic, you know, there's a big clinic in Seattle, Washington, that has opted out totally. So it's not unusual to have people doing that, and psychiatry is the highest specialty for opting out. And George, just for your comments about the Medicare and Medicaid, this is the real world experience. The minority and the Hispanic and the

black are having trouble, even with Medicaid and Medicare, or Medicare and Medicaid as secondary. This is a real world experience.

DR. BERENSON: Ron, I just wanted to point out, nonparticipation doesn't mean opting out. It means you're not taking Medicare rates. I know you're able to --

DR. CASTELLANOS: I guess you didn't clarify that. I need to look at it.

DR. BERENSON: Okay.

DR. CASTELLANOS: That's how I interpreted it.

MS. BOCCUTI: Maybe, if I could just have it for one second, I'd distinguish between the two. So as Bob was saying, you can sign a participation agreement and that means that if you sign a participation agreement with Medicare, then you agree that for all the services you provide to Medicare patients, you accept the full -- the Medicare amount as payment in full. You do not balance bill the patients. And we have 95 percent of physicians are doing that -- or 95 percent of physicians and other practitioners.

The opting out means that you can enter into whatever charges you want with the Medicare patient, but the

Medicare patient can no longer get any reimbursement for those services himself or herself, nor can the doctor. So they become out of pocket.

DR. CASTELLANOS: I appreciate you saying that and I'm aware of that. I guess it wasn't clear in Tab A material. I'd like to look at that again.

MR. HACKBARTH: Bruce?

DR. STUART: I support the recommendations and you've done a good job on this. I was really intrigued by some statistics on Slide 2, and it's the third bullet point, and if you do the math, it looks like 60 percent of practitioners who are billing for physician services are physicians, which means that 40 percent are not physicians, which raises a couple of questions. The first is, when we look at changes in rates of physician reimbursement and the updates, these are for physician services whether provided by physicians or not, is that correct?

And then the second question would be, do we have any sense of the volume of services that are billed by physicians versus not physicians in this sector? I'm assuming it's overwhelmingly physicians, but I really don't have any sense of that.

And then, third, and I'll let you see where this line of reasoning is going, if that volume of services that are provided by non-physicians is growing, then it would suggest that if you're doing your focus groups, you would also want to be talking to the non-physicians that are providing these services, and then the question is, are you doing that?

DR. HAYES: So we do -- when we do our volume analyses, we included all services billable under the fee schedule, and so that would incorporate services -- take office visits, for example, that are billed by nurse practitioners and PAs. It would include -- a big category is outpatient therapy, including therapy billed by therapists billing independently. There are other categories that are billable -- chiropractic services and on and on. But I just don't have any figures offhand, but I take your point about making that differentiation between physicians and non-physicians. But the vast majority, you are right, would be physicians billing for services, of those categories.

DR. STUART: I guess where I'm going here is that to the extent that some of these practitioners are providing

primary care, and this would be largely the nurse practitioners and physician assistants, and we focus just on physicians, primary care physicians, we may be undercounting the availability of services.

DR. HAYES: Well, just on that point, certainly in our volume analyses, we are including the services billed by the non-physicians, and then recall on the fee schedule adjustment for primary care, we identified nurse practitioners and PAs, advance practice nurses, as among those that would be -- among those that would have the specialty designations that we thought should be eligible for the adjustment.

DR. MARK MILLER: A couple of clean-up points. I'm going to look at Joan. I don't think in our focus groups we focused on this group of providers yet.

DR. SOKOLOVSKY: [Off microphone.] That's not something --

DR. MARK MILLER: Okay. Yes, and again, so we take your point there.

But then I wanted to ask you, on participation rates and the PAR rates and all of that, is that just physicians or is that also going to be the non-physician

providers?

MS. BOCCUTI: It includes some non-physician providers. It includes, yes, other limited license practitioners, yes.

DR. MARK MILLER: [Off microphone.] So we might not be completely off.

MS. BOCCUTI: But notice, also, I think Carol also speaks with some other professionals, like physical therapists, and there's been other opportunities for practitioners who bill on the physician fee schedule to talk with other analysts here, if you wanted to -- okay.

MR. BUTLER: Okay. This is a tad of round two, but then you won't hear from me in round two. Just on the -- everybody is talking about the Mayo example, and I don't want to further cloud the issue, but I do think that, sure, it's just five physicians in one site with 3,000 or so Medicare people, but also in those announcements, it said, we lose $120 million in our Phoenix market on Medicare, I think was the statement, and that it came in the context like this may be a strategic direction of a large nonprofit multi-specialty group practice. And if that, in fact, is something that is emerging, it is something that we should

understand as Commissioners and try to stay ahead of it.

The second comment, just a little bit on the concierge, I'm pretty familiar with these, and I think the most prevalent model actually is you get -- you charge $1,500 or so a year and for that you get a comprehensive exam, but you're not opting out. You are still staying in Medicare and charging Medicare fees, but you are taking -- you are suddenly managing far, far fewer patients. Therefore, you are reducing your capacity because you're getting the $1,500 fee, but you're still participating in Medicare. So it's a little different model than just saying, I'm out.

Thirdly, a good thing to keep track of, I think, would be all of those that I know have opted out truly and just aren't taking any. I don't know of a single one that has opted back in. So it would be interesting to know, if you lose them, are there any examples where we can find you can get them back, and my guess is there's not much, but it is something that would be interesting to know if we could get it in the future.

DR. BORMAN: Well, Bruce pretty much asked one of my two questions, but I'd just like to speak just a little

bit further to this breakdown between physicians and other people billing under the physician fee schedule. Now that it's 60-40, I think that it would be informative in the future to perhaps look at some of the practice patterns because there may, in fact, be growth in different sectors. We need to know that a little bit, and particularly as we talk about some of the workforce discussions that we've had, the right mix of workforce and so forth. Some of this conversation and some of these data would be very helpful to that conversation, I think, going forward. So we may not have something or need it for this particular conversation.

The other thing would be, for example, we heard mentioned a couple of times access to psychiatry services and, for example, the psychology-psychiatrist breakout and some of that might also be of interest. So there's multiple levels at which that breakout might be of some interest.

The one other question I have is more of a process one. Since the proposal is to reiterate the budget-neutral primary care bonus and, I believe you said, feature it prominently, whether we will formally reaffirm that vote or not, I know we did once when we re-mentioned it previously, although I think we have not always re-voted when we have

reaffirmed prior recommendations. So if we could clarify that, that would be helpful.

MR. HACKBARTH: On the process question, Karen, we will not be re-voting on the primary care recommendation. As with other recommendations we are rerunning, it will be included in the text, offset in a text box, which is what is meant by highlighting, and it will be included on the facing page that begins each chapter where we have, you know, the gray page that says the recommendation is X and the vote was Y, and then there will be language there that refers the reader to prior recommendations of interest in that sector. So the primary care would be referenced there. Does that answer your question?

DR. BORMAN: It does. It is just my recollection that we did actually --

MR. HACKBARTH: Last year --

DR. BORMAN: -- re-vote on it once, and I wasn't sure --

MR. HACKBARTH: Yes.

DR. BORMAN: -- what the rationale that applied and whether or not it was applicable again this year.

MR. HACKBARTH: Yes, and I won't be able to

reconstruct all of the circumstances a year ago, but a year ago, our plan was not to re-vote it. But as the discussion evolved that day, there were some Commissioners who asked that we re-vote on it as a way of emphasizing the Commission's -- the importance the Commission attaches to it. And so last year, we did actually re-vote it.

Rather than get into questions this year of which ones we re-vote and which ones we just run in text boxes, the general rule I laid out at the beginning was we are not going to re-vote the old recommendations. We will put them in text boxes. We will highlight them on the facing page and we'll handle all of them the same. Okay?

DR. BORMAN: I appreciate the clarification.

MR. HACKBARTH: Okay. Before we go to round two, I just wanted to focus in on the issue of access to primary care services for Medicare beneficiaries. In your presentation, you made some broad statements about that, but for the benefit of the audience, I just wanted to walk through some of the data more specifically.

This question of whether Medicare beneficiaries have adequate access to primary care services in particular is one of the questions that I get asked most frequently

when I testify on these issues, and that's why I think it's very important.

So for Commissioners who have the draft chapter, it's the table on page nine of the chapter, and this is based on survey data where we ask Medicare beneficiaries and then people with private insurance about their access to care. Remind me about the timing and the sample size of this survey.

MS. NEPRASH: The survey happens every fall and 4,000 people on Medicare and 4,000 people on private insurance were posed these questions.

MR. HACKBARTH: Okay. And then we did some oversampling to get enough numbers for minority questions and the like.

MS. NEPRASH: We did. This year, we oversampled African Americans, Hispanics, and the "other" category, which includes Asians, Alaskan Natives, Hawaiian Pacific Islanders, and Native Americans, and in each of those three categories, we oversampled to make sure that we had at least 450 respondents.

MR. HACKBARTH: Okay. So the part that I want to focus on is finding a new primary care physician, which, as

the Commissioners know and those in the audience who follow our work know, that's been the area that's most troubling, where we see the potentially most worrisome numbers.

The number of Medicare beneficiaries seeking a new primary care physician in any given year is about six percent -- or it was six percent in this sample, this national sample, let me put it that way, is that right? Okay. So we're talking about six percent of Medicare beneficiaries here.

And so for the last four years, we've asked the same question about whether a beneficiary has a problem in finding a new primary care physician if they need to find a new one, and they're asked to say whether they have no problem, a small problem, or big problem.

For 2009, the survey done last fall, 78 percent of Medicare beneficiaries said they had no problem finding a new primary care physician. Twenty-two percent, therefore, said that they had some problem and characterized it either as a small problem or a big problem.

The comparable number for privately insured patients ages 50 to 64 is 71 percent said they had no problem, so 71 percent less than the Medicare number. So

the private patients are having more problems. So 29 percent, by definition, of the privately insured patients said they were having a problem finding a new primary care physician as opposed to 22 percent of the Medicare beneficiaries.

This is national survey data. In any given market around the country, the results could be different from this, and it's very important to emphasize that. Among the reasons that the numbers can be different than this is that the local dynamics, the local supply and demand for health care services in general and primary care services in particular can differ market by market.

So an example that I've cited in the past is a rapidly-growing community, like my home town, Bend, Oregon, where we have also a lot of retirees moving into the market, areas like that are particularly vulnerable to an imbalance in supply and demand of services. So in Bend, Oregon -- I don't know what the numbers are, but you could have a much higher percentage of Medicare beneficiaries looking for a new primary care physician because there are a lot of retirees moving newly into the area. With the supply relatively fixed or lagging behind the demand, you could

have much different numbers in Bend or any number of other communities around the country than these.

And when you're talking about the Medicare population, with 40-plus million people, even small percentages of beneficiaries having problems, it's a lot of people that can generate a lot of Congressional mail and a lot of appropriate Congressional concern, a lot of newspaper stories.

But looked at on a national basis, from these data in this most troublesome area of getting access to primary care physicians, Medicare beneficiaries report to us that they have access that is as good as or better than privately insured patients age 50 to 64. That's not to say that access to primary care services for Medicare beneficiaries is not a problem and we shouldn't worry about it. Far from it. I think the trends in primary care for all types of patients are bad, and as a society, we need to be intervening to try to improve that. But what this does suggest to me is that on a national basis, to the extent we have problems, it's not because of Medicare payment rates being too low. It's much more likely to be because of market-specific factors related to the imbalance in supply

and demand.

Okay. So let's go on to round two. Jennie?

MS. HANSEN: If I can just add one more factor of studying this phenomenon of access to primary care services is in 2011, it will be the first turn of the Baby Boomers cohort turning 65. So I just wonder if that factor of numbers will increase, as well, rather than that it's beyond the six percent we will be looking at. So I think if we just factor in some of the demographic changes of who is going to start qualifying for Medicare.

And in a separate context, I think part of the reason there is more mail being generated about -- concern about primary care include the context of health care reform, that if another 30 million people enter into the health care access system, there has been some reaction, I know, by current beneficiaries over concern of further access if, in fact, certain pockets are already experiencing that.

So I just want to -- that's part of the reason of studying it further and tying together Bruce's question about who actually gets defined as a primary care provider. So somehow, perhaps some way to look at this in a broad

context, because it is about preparing people and then who also provides the primary care and what the demographics are. So it's a more composite picture to really begin to take a look at.

MR. HACKBARTH: And I agree with those points, Jennie. Just for the record, again, I want to emphasize, nothing that I said should be interpreted as, oh, I think there aren't any problems with access to primary care. I think that as a country, we're facing serious problems, potentially, with access to primary care. I think they're going to have to be met at least in part through changes in how we deliver primary care, more use of advanced practice nurses and other non-physician practitioners. There's no way we're going to be able to ramp up the number of M.D.s, nor would it be efficient and appropriate to do so, in my view. So I'm concerned about these issues, but I just want to be clear about what the data show currently on access for Medicare patients versus others nationally.

DR. BERENSON: Just one little thing to add is the impending retirement of many of the Baby Boom doctors who are treating the Baby Boom patients who are coming in, which needs to be looked at, too.

MS. BEHROOZI: Yes, actually, thank you. That's one of the things that I wanted to talk about. Glenn, you emphasized the word "current" and Jennie is looking forward to the future. I'm concerned that when we look back and ask people if they had a problem, they had a problem that we are now looking at in the past and it's probably getting worse as we speak. So I don't necessarily mean to say that the data in that patient survey is inevitably getting worse. I'm just concerned with only using a backward look and rather trying to figure out what are the canaries in the coal mine kind of things that will help us plan better for the future, and so things like doctors retiring.

Maybe drilling down a little bit more or figuring out some better way to get information from the physicians themselves, because the -- on, I guess it's pages 18 and 19, it's really kind of all over the map. You really can't tell whether physicians are accepting new Medicare patients consistently. It's many of the paragraphs refer to some or all new patients. In what ways are they being selective? Maybe there's a different way to -- I don't know to what extent those surveys drill down. Maybe there's a different way to do it. Maybe you call a physician's office and say,

I would like to schedule an appointment. I'm a patient whose coverage is Medicare.

I've recently been having this experience on behalf of my parents, and ultimately, I can find someone who will take them, but I always get a no or two along the way, and I don't know if that means things are getting worse. It's so anecdotal and I feel like there's a way to get better information somehow from physicians about what's going on out there and what's likely to be happening as we go forward.

MS. BOCCUTI: Can I just mention a couple things? You know, I think about this a lot, as you might imagine, and I think it's good that we look at both the physician reports and the patient reports, because they're not always going to match, because, you know, you could have beneficiaries all being able to ultimately find physicians, but it doesn't mean that all physicians are taking those patients. So I think it's important to look at the whole picture, and if you're only surveying physicians, you're not actually getting what the beneficiaries are experiencing. But if you're only surveying the beneficiaries, you are getting that look-back issue. So I think it's helpful when

we look at both of these. The National Ambulatory Medical Care Survey does ask these to physicians annually and we try to put that in.

But I do want to say that, as Hannah mentioned, our survey coming out in the fall that we report is the freshest that you are going to find. It is as close to real-time as we can get, and it's in the same vein that you say of trying to look for canaries in the coal mine. You know, when we're getting data that's three years old, that's not going to be helpful. So we're trying as best we can to get at this.

Some people do get at the canary in the coal mine, ask physicians what they're planning to do, you know, will you consider dropping these patients, and that has some value, but it can get very overstated and it doesn't -- it cannot be what we rely on, what they're responding to those kinds of questions.

DR. SCANLON: Yes. To follow up on what you were saying about the idea that there are differences in access issues with respect to local markets, I mean, I think that raises two different sort of conclusions. One is that there's a need for much better data about what's happening

in local markets, because to look at things from a national picture does not provide sort of us with the right information to guide sort of policy.

The second one, though, is kind of then what do we do about it when we have local problems as opposed to sort of a national problem, and the idea that we then raise fees nationally is too blunt, too inefficient of an instrument to think about in terms of dealing with all local problems because some of those local problems are really because markets there are distorted.

As we had a session a few months ago on consolidation in markets, and while a lot of that work has been done on the hospital side, there's also some of the same kinds of things going on on the physician side, and for Medicare to become, in some respects, the next victim of that is not something that we want to do. So that, I think, are two important sort of implications for the future, need for refinement in our thinking and in our instruments.

To go to this question about primary care, though, I think, and since we're repeating the recommendation, today's discussion has for me sort of been more in a direction that I've been comfortable with than where we were

in the past, and that is to recognize other types of personnel, other types of professionals that may substitute, because a lot of the discussion in primary care shortage has been in terms of the number of people that go into residency programs and number of primary care physicians. And some of that discussion has been in spite of the fact that GAO reported we've had a bigger increase in the number of primary care physicians per capita over a ten-year period than we did in terms of the number of specialists per capita. And on top of that, we almost doubled the number of nurse practitioners and we had a very large increase in sort of the number of physicians assistants. So there's this issue of sort of what are the data telling us about sort of primary care supply.

I think you then also need to combine that with what's the optimal sort of for the future, and as you said, we can't necessarily afford the number of physicians that we've had in the past to do these kinds of tasks, and the idea of substituting nurse practitioners is one step. We're now seeing -- we've had at least one piece in JAMA about sort of more disruptive technology. It doesn't even have to be someone trained as extensively as a nurse practitioner to

do some of the things that we're talking about.

And we need to think about these for the future, because if you look at other countries that have had a much better record in terms of controlling costs and keeping costs down, it's not because they've had more primary care physicians or had fewer physicians necessarily. Germany, which has one of the best records, has a lot more physicians and has more specialists as a share than we do. It's how you use your personnel that's the key to sort of this as well as the types of personnel that you have, and I think we have to think about that for the future.

DR. CROSSON: While I support the recommendation, I'd just like to underscore one point that was made in the presentation and that has to do with the question of whether we have a problem in the adequacy of the fee schedule for psychiatrists, and that's not to take away from Bill's point about other mental health professionals. But I think as we focused in the last few years on primary care, adult primary care particularly, and we recognize that perhaps there were growing inequities, if you want to use the term, in the fee schedule, a lot of that was caused by the ability of some providers, some specialists, to increase their volume to

participate in that 90 percent growth curve, volume per beneficiary curve, that we saw in Slide 9 and others not. And certainly adult primary care physicians fell in that category.

I would believe, without the evidence, but I would believe that psychiatrists also fall into that category, and Karen has mentioned general surgeons and there are others. But if, in fact, in the opt-out category, as you noted earlier, there's an overrepresentation of psychiatrists, perhaps that's an additional indication that there may be a problem. And if you add Jennie's point that we're going to see through health care reform an introduction into the stream of care of people who have not had care before, some portion of those, whether that's overrepresented or not, some portion of those are individuals with mental health problems.

So it just seems to me that as an add-on to the work that we've done with respect to primary care, perhaps in the future, we should dig deeper into the issue of the adequacy of access to psychiatric and other mental health services.

DR. BERENSON: Yes. Just picking that up, I mean,

one lens to look at an issue is primary care and non-primary care. Another lens is physicians who predominately do evaluation and management rather than procedurally-oriented services.

One of the more interesting articles I've read in recent years was a Wall Street Journal piece a few years ago about the demise of the specialty of neuro-ophthalmology, who basically are cognitive doctors. And there were some quotes from some of them saying they gave up that specialty and are now taking out cataracts.

So that, I think, is what Kevin's agenda would help us get at, is not only the primary care issue, but the balancing of E&M and procedural. And I know the RUC is spending a lot of time trying to get that right, as well, but I think that may be one of the things we want to look at, as well.

DR. KANE: Yes. I'd like to pick up on something that Bill was starting down the path of. I was just recently in two different markets, one in South Florida and one in Louisiana, where I was told that the private rate for physician fees were 70 percent of the Medicare rate, which means in other markets, if we're on average 80 percentage of

private, that there's a huge disparity going the other way, as well.

And I think we really owe it to ourselves to look at the private-to-Medicare payment rates across different markets and also correlate that to the degree of consolidation of the physician market, because it's pretty clear to me, as with the physician side, that the failure to enforce antitrust is a huge problem for Medicare access. And I think the only way we can make that case is to really start collecting the data. Even if we can't do local adjustments, we can say there is a problem here and it looks like it's got to -- I'm pretty sure you're going to find it has to do with consolidation of systems. And physicians are often consolidated within the hospital systems. And people have literally told me that, too, that that's why they are in a consolidated system, is not to provide better integrated care, it is to get better private sector rates.

So I think we just can't keep pretending that looking at the national picture gives us a view of anything, and it certainly doesn't give us a view of the remedies or potential remedies that would be nationwide if we could actually insist on the enforcement of antitrust, and perhaps

it needs better definition of what a market is, but there's a real problem, it seems to me.

The second observation I'd like to make, and this comes -- I've already told Glenn this -- from going to the doctor with my mother, and I'm sure all of us have these examples, but only a part of the visit was about my mother's medical problem and the other part, and I would say the longer part, was about this physician's dissatisfaction with Medicare and telling my mother falsehoods about Medicare, that Medicare is eliminating cardiology services.

So we have a real need -- I mean, you know, it was hard to keep a straight -- I didn't keep a straight face. But there is a lot going on in the local markets of terrible misinformation, including in the physician's office. And at a minimum, I think seniors need to be educated to, A, resist that, maybe even report on providers who do that, and perhaps we need some kind of PR contract or effort to better educate seniors as to the level -- I mean, this is really making the seniors think that the government -- just reinforcing this whole thing that government is bad and Medicare can't do anything right, and it is being perpetuated by physicians.

So I'm still furious that this person said that. Of course, I reeducated my mother immediately.

[Laughter.]

DR. KANE: I think we really need to take this seriously, because I think if you're thinking about what's the pressure on Congress, it's coming from these massive misinformation campaigns and they've got to be taken seriously. Even though you and I think it's outrageous, my mother doesn't know. So I think there's a lot of seniors out there who are being manipulated into thinking Medicare is out to destroy their medical care and we need to, I think, at least recommend something be done about it.

DR. CROSSON: And Nancy, I just want to suggest perhaps changing physicians.

DR. KANE: Oh, absolutely.

[Laughter.]

DR. KANE: I've already talked to Ron about another cardiologist reference. But I don't think this is uncommon, and I think Ron will agree with that. I mean, he's said the same.

MR. HACKBARTH: Yes. I want to just ask Cristina and company to pick up on that first point. I recall that

the Center for Health System Change did a study, I don't know, probably four or five years ago now, looking at the variation in the relationship between Medicare and private fees, and as Nancy says, in some cases, it's like the national average. Medicare is 80 percent to private. In other cases, it goes the other direction.

And I recall what they found, though, was that access -- satisfaction with access to services for Medicare beneficiaries was not correlated to the gap between private and Medicare fees. Is that -- do I remember --

MS. BOCCUTI: That's exactly the results that they found, yes.

MR. HACKBARTH: Yes. It might be useful to sort of update that analysis and maybe add some new wrinkles to it.

DR. MARK MILLER: If I could just say something about that, so I think we've had some of this discussion here. I'm forgetting exactly what I've heard in the office and here. But we do have work coming forward on the kind of consolidation and looking at the relationship to pricing and we're going to try to be looking at it both on the hospital and physician side of things. Anne Mutti and Carlos and

probably a couple other people are involved in that. So that first thought about consolidation and what's going on, you should see more of that.

DR. STUART: Thank you. Just to emphasize basically on Jennie's point and Bob's point about let's not just focus in on primary care, let's focus in on all doctors, I think that's important.

Nancy brought up a very good point about what's happening in the little pockets, and I was involved a little bit with Nancy in a discussion. I've never seen so much distrust, misinformation, and outward contempt by the physician community. I'm not quite sure why, and one of the efforts that I've always said is not just educating the patient or the Medicare beneficiary, but somehow we're way up here with, as, Jay, you mentioned, where the eagles fly, and where the doctors are down in the barn picking out corn. And there's a --

[Laughter.]

DR. STUART: The information is never getting down there and we need to do a better job on that.

Glenn, you did such a good job with Arnie explaining some issues, and one of the things I want you to

kind of make a point on when we talk about equity and sustainability, especially when it applies to the physician side in the face of -- and this is how physicians look at things. We have an SGR cut of 22 percent coming up. Now, whether it will happen or not, I don't know.

Medicare pays 80 percent of primary care. Hospital payments over the last nine years have gone up 34 percent. Physicians have gone up 1.6 percent. Our costs have risen anywhere, depending on MEI or NGA, 20 to 30 percent. These low Medicare payments are making a big difference to physicians and a lot of us are now trying to affiliate with hospitals or that. I think the AHA had some pretty good studies on that.

In my discussions with Glenn earlier this week, we talked about this and I asked him if he would perhaps put this in a better context for the physician community and for the public.

MR. HACKBARTH: Well, I won't repeat the part about why I think our hospital recommendations are appropriate and apply appropriate pressure there, and so let me focus on the physician half of it, and I'd ask Kevin to put up Slide 9.

So you had made this point at the December meeting, that there's a disparity between the updates that physicians have received and the increase in their input prices, so I had asked Kevin to put together the data for the full period of the SGR, and that's what this slide is.

Now, this does use the MEI, and earlier I asked whether that includes the productivity adjustment and I understood the answer was yes. So if you just did input prices without the productivity adjustment, that MEI line would be moved up, and so the gap between the updates and the MEI would become larger.

However, to me, a very important line is the red line, and it's the red line that determines total physician income from the Medicare program. And there, as you well know, and as illustrated by the line over the dozen or so years since SGR went into effect, notwithstanding SGR, we've had consistent growth, fairly rapid growth, in per beneficiary Medicare expenditures for physician services, which means higher Medicare income for physicians. And if you did a comparable line for hospital services, you would see some growth in hospital, but the slope would be much less than this. So one of the ways that physicians are

benefitting from Medicare beyond the update factors is through the growth in volume.

You and I agreed when we talked the other day that this isn't the right way to run the system, to squeeze the unit prices and let the volume run free. SGR was a poorly conceived effort to try to bring together pressure on volume with unit prices. It was flawed in conception, from the outset. It was destined not only not to work, but probably to make the problem worse, and it has.

But we need other payment methods that encourage the efficient delivery of services, address the problem of volume directly, so we don't have just unit prices the only tool that we can use to try to keep Medicare's expenditures reasonable.

Given this slide, as I said to you on the phone, I think we are being equitable in our treatment of physicians. Even though they're getting less than input price increase and the health care recommendation is short of full market basket in the context of P4P, I think we're being equitable.

Other comments? Tom, last one, and then we need to vote.

DR. DEAN: Just a couple of comments that sort of

follow on what you just said, and to follow up a little bit what Bill said, I think we talk about the shortage of primary care, and obviously it's real, but I think if we're really going to deal with that, and it's probably already been said, we really need to sort of restructure how we do primary care, because we know that the way it's being handled today is very inefficient and we're not using our skills either at the physician level or the PA-nurse practitioner level anywhere nearly as effectively as they could be, and a lot of it has to do with the payment system. I'm sort of repeating a lot of things that have already come up, but it's so important that I think we've got to keep it in the forefront, because if we just operate on the basis of the structures that we've used, we're just going to get ourselves deeper in the hole, I think.

And I guess just on that, PAs and nurse practitioners can do a tremendous amount. They've saved my practice many times. On the other hand, the reality is that today, the majority of PAs and nurse practitioners are going into specialty practice and not into primary care, so I don't know. We could go on forever on this. But we really need some major restructuring. I'm a little hesitant -- I

mean, we could get into a long discussion even on the time issues. I think, to me, that's a waste of time, because I don't think we'll ever get it right and it's the wrong direction in terms of really moving the incentives toward a more efficient system.

MR. HACKBARTH: I agree, Tom. Although I think the primary care bonus is a good thing to do, I think we need a change in the payment method for primary care. I don't think it's a service that's best purchased or funded on a fee-for-service basis, as Bob Berenson and many other people have argued. A medical home is an effort to begin directing moving us towards a new way of purchasing primary care.

Okay, time to vote. So will we put the recommendation up, and I think we just have one this time, correct? All in favor of the recommendation on physician update, please raise your hand. I forgot to raise mine.

All opposed?

Abstentions?

MR. HACKBARTH: Okay. Thank you very much.

I've got us behind schedule again.

So, the last session before lunch is Ambulatory

Surgery Centers.

DR. ZABINSKI: Today, Ariel and I are going to discuss payment adequacy in ambulatory surgical centers, or ASCs, and before we start, we'd like to thank Hannah Miller for her excellent assistance on this project.

As we begin our discussion of payment adequacy, important factors to remember about ASCs include per set total Medicare payments to ASCs in 2008 with $3.1 billion. The total number of fee-for-service beneficiaries served in 2008 was 3.3. million.

ASCs are a source of revenue for many physicians, as 90 percent of ASCs have some degree of physician ownership. Also, CMS substantially revised the ASC payment system in 2008, linking the payment for most services to the payment rates in the outpatient perspective payment system, and increasing the number of services covered by 32 percent and allowing for separate payment for many services that had been packaged into the payment rate for the associate surgical service.

Finally, ASCs will receive a payment update of 1.2 percent in 2010, which equals the full CPIU as mandated under current law.

Over the coming slides, we will discuss some of our standard measures of payment adequacy, including beneficiaries' access to care and the supply of ASCs, ASCs' access to capital, and Medicare payments to ASCs; however, we were not able to evaluate ASCs quality or costs because ASCs do not submit those data to CMS.

We have found evidence that indicates that access to and supply of ASC services has been increasing in recent years. Looking at the first row of numbers on the table, from 2003 through 2007, the number of fee-for-service beneficiaries served grew at a robust rate of 6.4 percent per year. This growth slowed to 2.8 percent in 2008, but this number was held down because total fee-for-service enrollment declined by 2 percent in 2008.

In the second row, you can see that, over 2003 through 2007, service volume for fee-for-service beneficiaries increased by 10.2 percent per year, and growth in this measure remained high at 10.5 percent into 2008.

The third and fourth rows show that the number of ASCs increase at a robust rate over 2003 through 2007, but that growth slowed in 2008, and is slowing in the growth of the number of ASCs maybe due to the downturn in the capital

markets in the economy that occurred at the end of 2008.

Also, it's plausible that some investors are waiting to see how the revised payment system implemented in 2008 affects the existing ASCs before they enter the market.

And now, Ariel will talk about some demographic profile of the beneficiaries who receive ASC services.

MR. WINTER: At last month's presentation, George asked us to examine the payer mix and patient mix of ASCs and hospital outpatient departments. The available evidence shows that ASCs are less likely to treat Medicaid patients than hospital outpatient departments.

The first evidence we have comes from a 2005 survey conducted by the Medical Group Management Association, which includes responses from about 100 ASCs in multiple states. This survey found that Medicaid accounted for 4 percent of the average ASC's patients in 2005, while Medicare and commercial plans accounted for about 87 percent.

These numbers are similar to data collected by Pennsylvania in 2008, which showed that Medicaid patients accounted for 3.4 percent of ASC procedures, compared with 10.4 percent of HOPD procedures.

Commercially insured and Medicare patients represented about 87 percent of ASC services versus 79 percent of HOPD services.

We also looked at a study conducted by John Gabel and colleagues that examined referral patterns for physicians in Pennsylvania who sent most of their outpatient surgery patients to physician-owned ASCs. These physicians referred more than 90 percent of their commercial and Medicare patients to an ASC rather than a hospital, compared to only 55 percent of their Medicaid patients.

This table presents results from an analysis we did using Medicare claims data. Among Medicare beneficiaries who receive care in ASCs, 13 percent were dual eligibles -- in other words, they also had Medicaid coverage. Among beneficiaries who were treated in HOPDs, 21 percent were dual eligibles.

Other groups who were less likely to receive cares in ASCs than HOPDs included African Americans, beneficiaries under age 65 who are eligible because of disability, and beneficiaries who are age 85 or older.

The fact that ASCs are less likely to treat dual eligibles and less likely to treat patients who have more

comorbidities, they help explain why they treat a lower share of African American and older beneficiaries.

Now, go back to Dan.

DR. ZABINSKI: Another measure of payment adequacy is access to capital. For ASCs, the best measure of access to capital is the net change in the number of ASCs in a given year; that is, the number of new ASCs minus the number of ASCs that closed.

As we saw earlier, growth in this measure over 2003 through 2007 was strong, but that slowed in 2008, which was caused, at least in part, by the downturn in capital markets in the general economy, but those downturns are unrelated to Medicare payments, so changes to access to capital in 2008 may not be a good indicator of payment adequacy for that year.

Our analysis also shows that payments to ASCs has been growing at a strong rate. Over 2003 through 2007, payments per fee-for-service beneficiary increased by 8 percent per year. The strong growth continued into 2008, increasing by 9.7 percent over the 2007 level , and the services that were newly covered in 2008 under the revised payment system accounted for 2.9 percentage points of the

2008 growth.

As part of our analysis, we found that the number of surgical services per beneficiary and the number of beneficiaries served has grown quickly in ASCs but has remained largely flat in HOPDs, which is the sector with the greatest overlap of surgical services with ASCs. This may suggest that migration of surgical services from HOPDs to ASCs, which may present some benefits.

In particular, ASCs may offer efficiencies for both patients and physicians relative to HOPDs. In addition, cost per service and cost sharing per service are lower in ASCs than in HOPDs; therefore, a shift of services from HOPDs to ASCs has the potential to reduce aggregate program spending and aggregate beneficiary cost sharing. However, we are also concerned that the ASC/ growth does have the potential to increase the total volume of outpatient surgical procedures, which could in turn increase program spending and beneficiary cost sharing.

For example, most ASCs have some degree of physician ownership, and this could raise the possibility that physicians have an incentive to perform more procedures than they would if they had to provide all outpatient

surgical services in HOPDs.

An important issue regarding ASCs is that, in contrast to other healthcare facilities, ASCs do not submit cost or quality data to CMS. However, these data are important for three reasons:

First, they would allow us to fully evaluate the adequacy of Medicare payments to ASCs; they will allow for payments to be based on quality; and it would allow for an effective evaluation of an ASC market basket. This final point is important because, as we discussed at the December meeting, the variable that CMS uses to estimate CMS cost growth, the CPI-U, may not be an accurate measure.

So, to summarize our analysis of payment adequacy, our measures indicate that access to ASC services has been increasing and that ASC access to capital has been at least adequate.

In addition, we lack cost and quality data to do a fully effective evaluation of payment adequacy.

And as the Commission considers an update on ASC payment rates, several goals should be balanced. On the one hand, you want to maintain beneficiaries access to ASC services by paying providers adequately so that they are

willing and able to render services, but at the same time, you want to hold down the burden on taxpayers, maintain Medicare sustainability and keep providers under financial pressure to hold down their costs.

Then, in response to the Commission's discussion at the December meeting, we have the following draft recommendation: The Congress should implement a 0.6 percent increase in the payment rates for ambulatory surgical center services for calendar year 2011.

In addition, the Congress should require ASCs to submit to the Secretary cost data such as through a random sample of ASCs and quality data from all ASCs.

In regard to the first part of the recommendation, given our findings of payment adequacy and our stated goals, we believe a moderate update is warranted. Also, the patterns of access measures haven't changed much since last year; therefore, we propose last years recommended 0.6 percent update.

In regard to the second part of the recommendation, the Commission has recommended in the past that ASCs submit cost data to the Secretary.

And in a response to a request by Bob and Glenn in

December, we have modified the recommendation to recognize the potentially large burden on CMS and ASCs from collecting cost reports from all ASCs. Therefore, we suggest that cost data be collected through a random sample.

Finally, in regard to the quality data, the Secretary does have the authority to collect quality data from ASCs, and quality measures are available, but CMS has decided to delay the collection of that quality data to allow ASCs time to get adjusted to the revised payment system.

Implications of spending for this recommendation are that ASCs are poised to receive an update in 2011 equal to the projected CPI-U of 1.4 percent. Therefore, this recommendation would produce small budget savings of less than $50 million over 1 year and less than $1 billion over 5 years.

For beneficiaries and providers, we found strong growth in the number of ASCs and the number of beneficiaries treated in ASCs, as well as providers being willing and able to furnish services under the revised payment system implemented in 2008. Therefore, we anticipate this recommendation having no impact on beneficiaries' access to

ASC services or providers' willingness or ability to furnish those services.

And now, we turn things over to the Commission for their discussion.

MR. HACKBARTH: Perhaps you guys mentioned this while I was out, but I just wanted to go back over the CPI-U as the statutory index for the update.

In past discussions, and I think this goes back at least a year, we said the CPI-U doesn't make much sense as the index for ASC services, in part because it's a much more volatile factor. It includes consumer products, gasoline, and all those things, and as recent times have shown, with the economy, those numbers jump around a lot. They are quite sensitive to factors that really aren't relevant for how much ASCs should be paid. And so, we need, as the recommendation says, to get on with the task of developing a better index for ASCs.

The reason I wanted to highlight this is to highlight the fact that a recommendation here is a number as opposed to market basked minus something. And the projected CPI-U is 1.4 percent and so the .6 is not the statutory market basket minus productivity; it's a different number,

because we believe that it would not be appropriate to peg a recommendation to a volatile consumer price index. And so, this is a number not linked to a formula that seems a reasonable increase to me given all of the payment adequacy factors. So, I just wanted to make that explicit.

Can I see hands for clarifying questions.

DR. CASTELLANOS: Just two clarifying questions. I read, but I can't find it, that MedPAC previously recommended that ASC rates be dated to hospital outpatient rates.

MR. HACKBARTH: That was -- what we specifically recommended -- actually, I should shut up and let Ariel --

MR. WINTER: Recommended not that the rates should be the same, but rather the two payment systems should be harmonized and made more consistent, and we're referring there to the procedure groupings and the relative weights, not that the rates themselves should be equal.

MR. HACKBARTH: Yes, so the conversion factors are different.

MR. WINTER: Right.

MR. HACKBARTH: But the relative values are --

DR. CASTELLANOS: That was the recommendation.

And second one is, as you said, 90 percent of these have some degree of physician ownership, I was wondering, do you have any percentage of joint ownership, hospitals and physicians, because there's a good percentage of hospitals that also participate in this.

MR. WINTER: Yes. The MGMA asks about ownership and they ask about joint ventures, but they don't specify -- the way they report the data doesn't specify whether it's for the hospitals or corporate entities. So, we really can't distinguish between the two.

I think the estimate was 20 to 30 percent. I mean, it was fairly high but they don't distinguish between hospitals versus corporate chains.

DR. KANE: So, historically, Congress set the rates for ASCs and said they shouldn't go -- I mean, what was the historic update that Congress had in law before we took over this function?

MR. WINTER: The statute was that CMS -- the Secretary was supposed to rebase ASC payments every five years. And in between that rebasing, they were supposed to provide a CPI-U -- an update equal to the increase in the CPI-U. However, there were several statutory reductions to

that CPI-U update. The BBA reduced them for five years. So, for those five years it was either zero -- between zero and 1 percent. The MMA eliminated them for 6 years, from 2004 through 2009.

And so, there was this -- the default was the CPI-U, but in fact the default rarely was the actual update.

DR. KANE: So, I guess, if you look at the history of this sector and its expansion and its increasing numbers of volume per beneficiary, why would we raise it at all and not just stick with the zero that historically has been so successful in generating an enormous growth in this industry?

MR. HACKBARTH: Let me address that.

As always, what we're trying to do or what I'm trying to do -- whether you folks agree is another question -- what I'm trying to do is strike a balance. I think the fact that we have had significant growth is an indicator that the rates are probably not absurdly low.

On the other hand, it's always important to keep in mind that there are other factors driving this growth other than people just seeking profit, and there are changes in technology, changes in anesthesiology that mean that more

patients can be appropriately treated in outpatient settings.

And so, there are legitimate reasons for a lot of this growth, and as somebody who ran a physician group, including a large surgical practice, I know why our physicians love to work in ASCs, because they could be much more productive, and I wanted them to be much more productive, and so, those are very legitimate reasons.

Now, if we had zero update, would it mean that, oops, they'd stop treating Medicare patients or that positive growth would turn negative? I do not think it would, at least not in the short run. It does seem to me that after years of zero a modest update is the reasonable thing to do, and .6, I think, is such a modest update.

DR. KANE: I'm not saying it's inappropriate that they've had the growth. I'm suggesting perhaps that -- first of all, we don't have their cost reports, so we really don't know what's going on the productivity side or on the -- and I would guess -- I mean, I would think there are technological changes that are pushing things into ambulatory surgery center, having observed some of them myself with family surgeries, is that they're cheaper and

easier to do and much more easy to schedule, bang, bang, bang, bang, bang without a whole lot of emergency intervention.

I mean, in other words, I think it probably is quite a bit cheaper to do it. And, as you say, physicians, it's much more convenient and allows them to see many more patients in a window. And I'm just thinking one reason we see this enormous growth is probably because the rates are not only adequate but the cost to function is moving down, not up. And so, I'm just reluctant to give an update without any information on the cost side. That's all.

I mean, I agree there are wonderful reasons why it's happening, but I'm just wondering if we're really keeping up with the cost function side, given that it is technologically driven and is lower cost and has higher volume and higher productivity for the physician.

MR. HACKBARTH: Just a couple of reactions.

Just to be absolutely clear, and I know you know this, we don't pay the same rate even though the relative values are synchronized with hospital outpatient department services, we're paying less when the services are provided in ASCs.

If Mike Chernew were here, I'm sure he would renew the point that he made at the last meeting, which was that he's concerned about growing disparities in what we pay for the same service depending on the location of that service, and he was actually concerned about our squeezing -- causing that gap to grow by providing more in the hospital outpatient department than we do for ASCs.

The solution to that problem is to pay at the lowest provider -- the words that you're mouthing, which may be to pay everybody at the ASC rate. The challenge there is that -- as I said earlier, I run a group that did a lot of this business, and we knew that the patients we were treating in the ASCs were different from the ones that we were sending to the hospital. The procedure may be the same, but the patients are different. We were sending the easy cases to the ASCs and the patients where we might have complications, we might need backup, we were doing it to bring them in the hospital outpatient department. And so, there is some unmeasured selection here.

So, we've got a lot of imprecision in these parallel payment systems. Over time, we need to try to better synchronize them. All things considered, again, I

think this is a reasonable number.

MS. BEHROOZI: This is a really boring clarifying question, sorry about that.

On the recommendation, spending implication, in the paper it made it clear that because the assumption would be CPI-U that this is actually a savings, this is a decrease, in anticipated spending, the $50 million for one year. I'm not sure it's clear on the slight, right?

MR. WINTER: Yes.

MS. BEHROOZI: Yes. It looks like it is additional spending rather than a decrease in spending, right?

MR. GEORGE MILLER: If you could put up slide 6 and let me see if I can amplify on a couple things that Nancy said to bring clarity, at least in my mind, on this issue, because, Glenn, to your last points, though, while Michael talked about paying all providers the same, in my view you have to be in the same game and all things should be equal. The hospitals are required to have a lot more things than the ambulatory surgery center, including the quality point.

We hire staff to generate all that information;

currently, the ASCs don't. We have to have an ER; they don't. And this slide will hopefully make part of my point.

There is a significant difference between the makeup of the patients that the ASC choose and they don't choose, and they have the capability of making that selection, and most community hospitals or rural hospitals don't have that choice to self-select, as you just said, for any number of reasons.

I'm struck by the difference between the Medicaid patients that they select or don't select between the two. That is a significant difference, and I'm concerned about the statement that there's complete access. Well, it's not complete access for all beneficiaries, if you look at the ratio composition. And I don't understand why that would be a difference, especially if you're still serving the same population. I realize in ASC we're only talking about 20 percent of the total volume is Medicare; am I correct on that?

DR. ZABINSKI: Yes.

MR. GEORGE MILLER: Just 20 percent, okay.

But, and these numbers on this document is all patients; correct?

DR. ZABINSKI: Yes.

MR. GEORGE MILLER: Okay.

MR. WINTER: All Medicare.

DR. ZABINSKI: It's all Medicare patients.

MR. GEORGE MILLER: These are only all Medicare?

DR. ZABINSKI: Yes.

MR. GEORGE MILLER: Well, this even makes my point even stronger, right?

So, how do we say that all Medicare beneficiaries have great access when, according to this graph, and I appreciate you doing this, they don't?

DR. MARK MILLER: I think the --

MR. GEORGE MILLER: They don't.

DR. MARK MILLER: No, I hear you. I hear you.

MR. GEORGE MILLER: Okay. I'm sorry.

DR. MARK MILLER: We're not arguing yet.

MR. GEORGE MILLER: No, we're not.

DR. MARK MILLER: I mean, I think this goes back to the question that came up in the physician analysis. I mean, I think the blanket statement is, when you look at the numbers of users per enrollee in the program and you look at the volume of services, there's no indication that, for the

Medicare population broadly, and I'll come to your point in just a second, that this is going down or slowing down. It's still pretty much headed north.

Like some of the other conversations we've had on the physician side, that's a statement about national trends, and what we're trying to illustrate here is that you've picked up on a different point. We're trying to say, it's a different mix of population, going to these relative to the hospital, which is a point that you've made, and then you've said, and on top of that, there are differences of who makes it.

So, the access point is a national trend point. You, like in the physician world, are picking up on the fact that that's not every market, every person, in this case particular groups of people.

So, I think you're right, it does make that point, as well.

MR. GEORGE MILLER: Then, I guess I agree with Nancy. Quite frankly, then, if all Medicare beneficiaries don't have the equal access, why do we give them an update and the program is growing by leaps and bounds?

DR. MARK MILLER: Well, again, that kind of goes

back to the balance point which you -- I mean, the hard part of this, as much as -- we've talked about this between you -- among ourselves and between you. I mean, this always comes down to, in the end, we can put up data, but you guys actually have the hard job of drawing a judgment.

And to the exchange between Glenn and Nancy, I mean, the other point -- the last time we went through and talked about this and got to this midpoint, there were concerns expressed on the other side of the argument which, like Glenn mentioned, how far do we want these rates to drift apart, and a little bit of the driving blind, we don't have the cost data.

In some ways, you can interpret that as, like, well, no update until you give me the cost data. This is pressure to get the cost data, that type of thing. But that's what the judgment is, is striking a balance between all of those kinds of factors. And there were some arguments on the other side. I haven't heard them here today, but there were some arguments on the other side when we considered this last time.

MR. KUHN: Just one clarifying question on the issue of the CPI-U.

I've heard it referenced as a statutory requirements, but as I recall, when CMS put the provisions in place, that was a discretionary decision on CMS. So, is that correct?

DR. ZABINSKI: Yes, it's sort of a default. If I read the law correctly, it's that CMS can do anything it wants, but if it doesn't do anything ,then it's the CPI-U, and CMS has just decided to do nothing.

MS. HANSEN: Same chart here, probably the point on age. This is a question more on when people are more complex, and oftentimes, the people who are 85 plus, here, might be.

Is there a risk adjusted rate that goes along with it?

DR. ZABINSKI: No.

MS. HANSEN: No? Because if that's the case, one of the things I think I would support, George, and as we continue to array information on all these kinds of programs where there seem to be some selection of subgroups to be treated and other groups that perhaps go back to hospitals or outpatient departments, I'd like to keep this kind of visible tracking there, because it does convey who people

would prefer doing, and I can understand if somebody can get to a doctor's office on their own easily and not be confused. You can really do the scheduling of the procedures quickly, but it does convey an access slash some aspects of consideration of quality by virtue of whether -- to George's point about race and ethnicity, but in my case, you know I tend to bring up the whole issue of older people with multiple complex issues.

So, I appreciate this chart a lot and I just hope that we continue to keep it front and center as to what it means for access.

MR. WINTER: And we've done our own research into the issue of medical complexity and comorbidities and research that we funded with RAND, and we could bring some of those findings into the paper to flesh that out more.

And in terms of the risk adjustment question, there is no risk adjustment within ASCs for ASCs that chose more or less medically complex patients or older patients, but one could argue that some of the 40 percent differential between the outpatient conversion factor and the ASC conversion factor might reflect a difference in the severity of patients.

MR. HACKBARTH: It seems like we've had round one-and-a-half, here. Hopefully, that means that round two will be quick.

DR. BORMAN: You mention in the draft chapter the potential here for geographic confounding because of the heavy concentration of ASCs in five states, and I just wonder, we've mentioned in the past a little bit about periodically considering the effect of geographic or regional variation, and I just wonder -- it might be interesting, it might be totally nonproductive at some point to know if we can tease out an effective geography here, so that where there's not a whole lot of ASCs, is the differential the same? Does it reflect some inherent property, as we have all posited a bit about the nature of the patient, the nature of the procedure, the kinds of things a physician can achieve by concentrating his or her procedures there, or is it as much a reflection of the local market and the forces in the regional market.

DR. ZABINSKI: Just one point on Karen's comment.

One thing we did here is that we weighted the ASC population so that the states that have a lot of ASCs don't disproportionately count more than states that don't. I

think that might eliminate some of your concern, but I don't know if it does all of it.

MR. BUTLER: So, on behalf of George, one more comment on this.

I think if you looked at the Medicaid spread in particular and you were to take out the 20 or 30 percent of the ASCs that were -- where there's a hospital ownership, that number would drop a lot more, because most hospitals that are participating in joint ventures feel obliged because of their tax exempt status and their threats to make sure that they accommodate the same kinds of payer mix they are having in their hospital themselves. So, I think if you separated that out, you'd see a different payer mix in the -- I'm not saying it would be as high a percentage as in their hospital outpatient, but you would see a Medicaid presence in the way that you don't in some of the freestanding ones without hospitals' involvement.

DR. CASTELLANOS: First of all, I own an ASC, and I'm very proud of it because it allows me to provide an expert service to my patients expediently with good quality and cost containment. I have nothing to be ashamed about that at all. Similar to Glenn's comments, it really helps

the physician community.

I remember Bob Reischauer, we had this comment, and one of his comments were -- and I really appreciated that -- he said, it didn't really make a difference where the site of service was, what's important is the appropriateness. What's the best site to take care of that patient? And I think we need to focus into that a little bit.

From a MedPAC viewpoint, as we all know, we're prudent spenders of the taxpayers' money. Now, the data I'm going to give is I have not verified it. I got it from something that was circulated by the ASC community. There is a -- Medicare spending alone was 42 percent by doing these cases in the ASC. For the beneficiary, because of copayments, there's a savings of almost 56 percent. And to switch back from the ASC to the hospital is going to be a cost of 72 percent to the Medicare.

So, I think we need to consider that, also, but I think most importantly, we need to think about what Bob said, where it is most appropriate to do that patient.

DR. KANE: I mean, I'm still just not convinced, and I have nothing against ASCs, I think they're wonderful,

but I just don't feel that the update, particularly when you look at the updates for the post-acute sector, where there are largely zeroes, and largely because we say, hey, they're growing fast, therefore profit, the volume per beneficiary is -- and we're sort of saying -- but we can happen to measure their profits there, so we're giving them a zero update. I'm having trouble, and Mike's not here, but I don't think giving it a zero update affects this issue of the proper site. I think people are doing -- physicians have every desire to put the patient in the right site, because if they can get them in the ASC, they can do a much more efficient -- they can have a much more efficient day.

So, I'm not so worried that we're going to lose Medicare access to ASCs, I'm just thinking in this -- given our rationale for zero updates in some of the other sectors, I don't -- I am just not yet convinced that there should be a positive update in the ASCs, and I'm still waiting for that, oh -- and I hear you, that after eight years, maybe it's just time, but it is nowhere as near convincing as some of the other arguments we've had, and so -- and we've given zero updates quite a bit in the post-acute sector, too. So, I don't -- I'm just trying to get the consistency of the

argument for why there should be an update in this sector and not in, say, the SNF, where there's also a very different case mix in the hospital versus the --

MR. HACKBARTH: Just one clarification on that point. In the number of the post-acute sectors, we've recommended zero updates for a number of years, but they have not received zero updates. They have, in fact, received significant updates from the Congress.

Here, when we talk about zero updates, we're talking about what they actually got, zero updates for a long period of time.

Now, that's not necessarily dispositive of your issue, but I just wanted to make that contextual point clear.

DR. MILSTEIN: As you have pointed out, this is because we have so little objective -- we have a shortage relative to our usual update recommendations, objective facts on which to base our recommendation and therefore we're left with subjective factors, and I'm sure -- and notions -- including notions of fairness between providers and consistency. And I have to say I share Nancy's view that, given, when I look at the full array of what's here, I

would be more inclined in view of the limited facts we do have toward a zero update.

Another option that occurs to me would be, if we're going to be what some of us may regard as more generous in relation to this sector, should we up the ante in terms of what we want back?

I mean, Ron's pointed out, someone who is really an insider, that there's a major problem in this potentially larger problem in this sector with appropriateness, and should we up our trade so that we're giving essentially a blind .6 percent, which to my mind seems more generous than -- and somewhat inconsistent with some of our other categories, but the notion is the trade is cost data, random sample, quality, and use this sector as our maiden voyage, as it were, to collect appropriateness data. So, we've never had a meter for appropriateness, it's not easily done, but there are certainly ways that the specialty societies have approached this. And we also, when listening to our presentations on shared decisionmaking, appreciate there's really two dimensions of appropriateness. It's, A, does it meet professional guidelines; and, B, granted that it meets professional guidelines, has the patient really had a

balanced discussion of risks and benefits versus a non-neutral -- so, two different notions, and I will -- again, I mean, you have to keep the process moving in terms of whether it's too late or something like that.

MR. HACKBARTH: It seems to me that the cost report and the appropriateness are maybe a little bit different. So, let me just explore that.

One way to approach this would be to rephrase the recommendation and say .6 only if cost reports are concurrently required by legislation, with CMS left to address the issues about making that as efficient as possible and avoiding unnecessary burden.

We have some concreteness about cost reports and what that might entail. The appropriateness thing strikes me as a bit different. That's more imagining something that we'd like to see that doesn't necessarily exist on the shelf anywhere.

Ron and I talked about the importance of appropriateness and I absolutely agree in principle. I am maybe a little bit more suspicious of specialty developed appropriateness standards than others might be. In fact, I fear that that whole path leads to justification of low-

value services developed by people that have an interest in more of those low-value services.

So, I want appropriateness guidelines but I want them developed based on the best available evidence and I wish we were further along on that. I don't think that we're going to have that next year.

DR. MILSTEIN: Can I modify my recommendation and borrow from one of Jay's solutions in the last session and say that we would like the span of quality reporting to include appropriateness subject to the Secretary's determination of its feasibility. That way, I have a different view: I think it probably could move in that direction. I completely support your notion as to what the basis of judgment of appropriateness ought to be.

MR. HACKBARTH: I saw you nodding your head earlier, concurring with a change that said, .6 only in the context of cost reporting data.

So, we'll come back and take a vote and who would like --

DR. MILSTEIN: Plus the equality.

MR. HACKBARTH: Plus the equality, yes.

Let's finish the other comments, first.

DR. BERENSON: Yes, I'm persuaded that, after years of zero updates, a pretty modest increase is warranted, and if we then tie it to now new burdens to produce some data, I think that's -- I could support that.

I could just say, and this is for a future discussing, and in the context of the physician fee schedule, I've focused on imaging services where there is huge volume growth and we're not able to capture the issue of fixed cost being spread over much larger volume and making any adjustments when you have major equipment. It seems to me ASCs are a comparable situation where you have -- if in fact we can isolate how much of the volume is from new facilities versus how much is from increased volume at established facilities, I think we have an issue where we could learn and maybe make some adjustments with cost reports about the difference between average and marginal costs.

So, none of that is relevant for today's recommendation, but I do think that this is a ripe area for understanding a little more about that volume/marginal cost tradeoff.

DR. SCANLON: Yes, I'm not convinced that the

random sample is a good way to deal with the burden. I mean, filing a cost report is not the same as responding to a survey where somebody calls you up and you give your instantaneous answer, but if it was a constant sample, then the people that are in the sample know that they've got to keep their books a certain way and then it's not going to be an issue, but then there's the drawbacks of a constant sample.

So, I think that designing a relatively efficient cost report and one that's going to readily -- easy to complete -- would be an approach in terms of trying to reduce the burden on the facility.

In terms of CMS, there's the issue of rolling oversight and not attempting to audit all cost reports every year but to sort of move through the universe over time, auditing so that you both provide instruction in terms of how this should be done, and secondly to assure the integrity of the data, and you could even think about when you want to have an estimate for policy purposes, you deal with the audited cost reports or you deal with the audited cost reports and an audit adjustment to the unaudited ones.

So, I guess I take a different tact to trying to

make the burden smaller, but insisting on getting the cost issue.

MR. HACKBARTH: Yes, and I think those are good points.

So, what I hear you saying is that there are multiple variables, multiple dials that you can twist with a goal of minimizing the burden while still collecting necessary data, and I don't think that we should try to spin those dials here, and what I would envision is that we would include a paragraph that says, in essence, they ought to be looking at those dials to try to find an appropriate minimal burden that we need reliable information these dimensions.

MS. BEHROOZI: I just want to highlight a line in the draft on page 20, which is the only evidence we have of cost-to-revenue balance, where it says, in Pennsylvania where there was a study done, ASCs' average operating margins from 2007 to 2008 increased from 24.1 percent to 26 percent.

So, I thought it was around two issues, but I'm glad you raised it around one. I wasn't sure where the .6 came from, in light of the only evidence we have is that, yeah, this lower-cost alternative is producing savings, but

they're going to the providers rather than to the Medicare program.

So, I don't have a problem with a gap between HOPD and ASC rates. I don't have a problem with them growing. I'm happy that beneficiaries have a lower-cost alternative in terms of their cost sharing, and I think that the Medicare Program should be getting the benefit of the lower-cost alternative.

As far as appropriateness, being -- we certainly don't want the appropriateness determination being driven by that kind of profit available to the providers, and until we have an ACO kind of payment model where the provider has the incentive to chose the lower-cost alternative, but Medicare is also not paying too much for it, I think we have to live with the silos like we do in post-acute care where you're paying very different rates to different types of providers for providing what might be considered the same service, even if it is to different types of patients.

So, having said all of that, yes, I also would have supported a zero or, as Mike or somebody once said, can we do negative updates, but -- not because I want to punish them, but it seems like there's a lot of extra money in it,

but that's not necessary and I understand they haven't gotten updates in a long time, and I think with the modification that there's a requirement of cost and quality data attached to it, I would support the .6.

MR. HACKBARTH: I'm going to come back for a show of hands on a couple of questions here in a minute.

But Dan, do you want to just say a little bit more about that Pennsylvania data?

DR. ZABINSKI: Yes, right.

The size of the margins for the ASCs is -- the difference between those margins and the margins, say, for hospitals, isn't as great as meets the eye, because the ASC margins -- let's see, they pay the physician owner's salaries out of that, and then taxes come -- then the owner pays income taxes on top of that. While for the hospital, that sort of costs is already reflected in the margin itself. So, it's not as great as meets the eye.

MR. HACKBARTH: That the Pennsylvania data doesn't include all of the costs for --

DR. ZABINSKI: It includes different costs than what are included in a hospital operating margin because -- or it excludes some costs because it's not anything they can

really track.

MR. HACKBARTH: And the Pennsylvania data are for private patients or for Medicare patients or some combination?

DR. ZABINSKI: It's for all patients. It's for all patients.

MR. HACKBARTH: Other round two comments.

MR. BUTLER: I'm chomping at the bit.

I'm a little concerned at the direction we're headed. The difference between .6 and zero isn't a lot to begin with, but we need to worry about the Medicare side, and I don't want us to get in a position where these centers are going to say, forget about Medicare, we don't need it.

We've got a momentum as I mentioned last meeting of getting appropriate cases like cataracts into these centers, and if you go as far as cost report, here -- we've got one of these, and I'm thinking, my God, even a cost report like that, that's going to cost me $100,000-200,000 to produce, which would way overwhelm any -- I mean, that could be, in a $5 million operation, you're talking about a 6 percent number or something of -- it's a big expense.

So, leaping to, say, only if you get cost reports

could have a lot of marginal places that don't have a lot of Medicare, I'm not going to participate, forget it, and it's not worth it, and they may back off altogether. So, would worry a little -- cost data -- so, I just worry about that qualifier. I don't feel strongly between .6 and zero, but...

MR. HACKBARTH: Did you have something to say on that? How do you get to the $100,000 or $200,000?

MR. BUTLER: Any time you have a cost report that you have to produce and you've got -- these operations are likely to have one maybe outsourced, if that -- FTE doing the accounting on these things. Now, I'm into hiring another FTE to have to produce the cost report or -- I don't know of a Medicare cost report that's simple. Now, here we're doing it on the fly, but I know any time you have a regulatory requirement where you've got to put something official, it's not, like, well there's a couple of thousands of dollars to produce this thing. That's my guess. I don't know that, but it would concern me.

DR. CROSSON: Just before we take up the suggestion, I thought I heard something of what Peter said that confused me and we want to make sure we know what we're

saying.

In terms of linking the .6 to the cost recommendation, I thought, when we said it, that the .6 increase would only go into effect if in fact CMS goes ahead with requiring the sampling, not only those facilities who provide the cost data would get the .6 percent increase, right? Is that right? Okay.

MR. BUTLER: The recommendation we have on the table has the sampling as part of it.

DR. STUART: Yes, but it's not conditional.

MR. BUTLER: But if you say it's conditional upon that, saying the cost data, only if, versus cost report, that sends -- a sample using cost data is a very different recommendation than cost report, unless I missed --

DR. CROSSON: Again, maybe I'm missing what you're saying, but I thought what I heard you saying was that you think the recommendation of linkage means that you would only get the .6 if you happened to submit as part of the sampling process the cost data. I don't think that's what is being discussed.

MR. BUTLER: No. No, I understand that.

DR. CROSSON: Okay.

MR. BUTLER: The recommendation as it stands is fine with me, even if you change it to, the .6 won't go out unless Congress follows through with the sampling and the cost data; that's fine.

MR. HACKBARTH: Okay. So, now I think I'm starting to understand.

What I hear you saying now, Peter, is it is the specific language cost report which is content developed over years from the hospital sector and others. You want to avoid that language because it means to you something big and burdensome and expensive.

You are willing, if I just understood your last comment, to say that any update should be contingent on some approach for systematically gathering data on ASC costs, but you don't want to refer to it as cost report.

MR. BUTLER: Yes, I'm not only willing to support that reluctantly, I would be a strong advocate for that, yes.

MR. HACKBARTH: Okay.

So, with that clarification, it seems to me one path would be that one, stay with .6, make it contingent, and rather than write the language on the fly, what I'd

suggest is that we vote after lunch and we'll work on the specific words, make sure they're comfortable.

An alternative path is zero update, and I suppose you could do zero update plus the contingencies, as well.

And so, let me get a show of hands. Who would prefer the zero update approach, including the contingencies about collecting data?

Who would prefer the path, .6 with the contingencies?

Okay. Let us, during the lunch break, try to develop the specific language on the contingencies and then we'll come back and vote after lunch.

Okay. Before we break -- you have some proposed language?

DR. CROSSON: Well, no.

MR. HACKBARTH: All right. Let's do our public comment period before we break for lunch.

The usual ground rules, which Sharon could recite for us, but let me go ahead and do it so she doesn't have to.

Please keep your comments to no more than two minutes. Begin by identifying yourself and your

organization.

When you see the red light --

MS. McILRATH: Sharon McIlrath, AMA.

I just wanted to respond to some of the comments on the volume. I think that, if there is a discussion of volume in the paper, in the March report, that maybe it needs to be a little more nuanced. I think you would want to point out that, during that time frame, there were some very significant increases in coverage and that, at the same time, the deductible was held steady for a long, long time. So, more and more people were meeting the deductible, and part of the increase is, I believe, in the number of beneficiaries that are actually using the benefit and exceeding the deductible.

A lot of other things, technology, obesity, have contributed to that, but then also there is a shift in the side of service which was mentioned in the discussion about the growth in the outpatient departments and I think that the comparison that it would be more appropriate to make would be the comparison between what's happening on the physician side and what's happening in the outpatient part of the hospital world, and I think you would find that the

expenditures are actually -- expenditure increases are actually double. The volume increases over the last five years are slightly higher on the physician side, but the overall expenditures are probably about double, and I suspect, though I don't know this that if you looked at just the last year that the volume is slightly smaller on the physician side.

And then, to just also say that, if you really want to get a control on imaging or any other spending, you really do need to be looking at what's happening in all of the sites. Right now, with what has happened with the DRA cuts, with what's happened with the practice expense changes, and some of the impact that that has had on cardiology and on radiology services, you had some discussion in October, I think, on consolidation, about the number of services and physicians that are moving back into the hospitals and it does cost you more when that happens in the hospital, in part because there is a facility fee that is associate with the -- when the hospital owns the physicians, or employs the physicians, and also because, for those services, they are now considerable higher in the hospital side for most of those services than they are in

the physician side. So, you might want to do, when you're looking at volume, the same kind of analysis on the hospital -- on the hospital outpatient side that you do on the physician side.

I mean, we know that, in 2007, some of that imaging started shifting back into the hospital. What happened in 2008? Are there other services that are shifting back, because otherwise -- we always say that, you push on the balloon on one side, it comes out on the other side. You're not seeing what's happening. You are only seeing what's happening on one side, you're not seeing the full impact. So, just to suggest that the appropriate comparison is between hospital outpatient and physician, not between hospital and physician, and then to say, maybe you need to look in a little more depth.

MS. HIATT: I'm Joanna Hiatt with the American Hospital Association.

We appreciate the Commission's recognition of hospitals' negative Medicare margins which have been declining over a number of years by recommending a full market basket update for hospitals, but we are concerned about the recommendation on the documentation and coding

cuts.

The Congress has already given CMS appropriate authority on this matter. The issue at hand is really the timing of the cuts, and CMS indicated in their Inpatient Final Rule last year that they were considering a transition of five years to implement the documentation and coding cuts. They did not indicate, as was implied here today that they would implement all the cuts in either one or two years.

MedPAC's recommendation of spreading the cuts over only three years is therefore more aggressive than CMS is likely to be.

MedPAC recognizes that hospitals' negative Medicare margins are enough of a problem to necessitate a full market basket update, but then essentially takes that full update away by recommending these very aggressive documentation and coding cuts resulting in a negative guaranteed update that will further push hospital margins down into the negative territory.

So, we look forward to a discussion in the March report around this apparent paradox.

MR. SHIPLEY: Hi, Nick Shipley [phonetic] on

behalf of the ASC Association.

I just wanted to talk very briefly and echo some of the Commission's comments about the CPI index. Obviously, we agree that is a volatile index that does not cover a lot a lot of the issues that we're dealing with, the housing, the gasoline prices that cause it to swing, and it has created this large gap between HOPD reimbursement rates and the ASC reimbursement rates.

And as that gap continues to grow, as was cited with what was a multiyear freeze coming out of the statute from Congress, that does put increased pressure to offer Medicare or to cover Medicare beneficiaries in the ASC setting.

The ASCs are obviously providing a very efficient site of care. They do save to Medicare and to the patient as well, and we want to be able to continue that and hopefully the Commission will recognize that as it comes back from lunch and looks at the languages dealing with the update they're going to do.

MR. HACKBARTH: Okay. Let's go to lunch and we will reconvene at -- how about 1:45.

Okay. I'm for 1:30.

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

AFTERNOON SESSION [1:37 p.m.]

MR. HACKBARTH: Okay. I think we've got everybody now. Our first order of business is to vote on the ASC recommendation, and on the screen is a proposed version. What we tried to do was strip it down, emphasize the link between the update and the requirement for cost and quality data. My proposal is that we address the issues about how to best collect those data in the text as opposed to trying to use code words in the text of the recommendation itself.

In addition, as you can see, in the "in text" line, Arnie, we would include that in the text, but define quality data to include appropriateness.

Any reactions? Any suggestions for changing that?

MR. GEORGE MILLER: I don't have a suggestion for changing any of that language. From first blush I believe I can support it. But I do just want to stick a pin in my points about appropriateness of selection, whether it be age, by payer class, or race. And I don't know how to get at that, and maybe that's a quality measure we deal with somewhere down the road. But I at least wanted to put that issue on the record.

MR. HACKBARTH: Well, we've talked about this

before, you and I. I think those issues are really important. I don't think that they're unique to ASCs by any stretch.

MR. GEORGE MILLER: No.

MR. HACKBARTH: Okay?

MR. BUTLER: One quick question. Is it calendar year? I thought most of these are all October 1, federal fiscal years. Is this a different --

MR. WINTER: It's a calendar year. It's out on a calendar year, the ASC update. It was fiscal year. They moved it to calendar year in the MMA.

MR. HACKBARTH: There's some variety, so the physicians are on a calendar year basis, hospitals are on a fiscal year basis, federal fiscal year basis, and there's some variation among them.

Okay. Are we ready to vote? All in favor of this ASC recommendation? Opposed? Abstentions? Okay. Thank you very much.

And now we can move on to outpatient dialysis services.

MS. RAY: Good afternoon. During today's presentation, I'm going to first discuss two new pieces of

information that you did not see during last month's presentation. Then I'm going to summarize information about the adequacy of Medicare's payments for dialysis services. I will present a draft recommendation for you to consider about updating the composite rate for calendar year 2011. This is the last presentation before the March report.

Just a brief overview of the outpatient dialysis sector. In 2008, there were about 330,000 dialysis benefits, and they received care at nearly 5,000 dialysis facilities. Medicare spending on dialysis, called composite rate services, and dialysis drugs administered during dialysis was $8.6 billion.

Okay. So now moving to the first new pieces of information, George, you had some questions about kidney transplantation I'd like to address. On average, it is widely believed that kidney transplantation is the best option for individuals with end-stage renal disease. It reduces mortality and improves the quality of life.

With respect to trends, I'd like to parse through a couple of items here. First, as we saw in 2006, the 2007 data indicates that African Americans do not receive kidney transplantation in proportion to their prevalence in the

ESRD population. In 2007, African Americans accounted for 32 percent of end-stage renal disease patients yet receive 25 percent of kidney transplants. In the paper we summarize the myriad of factors that affect an individual's ability to get a transplant, and it is complicated. For example, clinical comorbidities can contraindicate some individuals from being candidates. There is the tissue matching process. However, there is research that shows that even after adjusting for some clinical factors and other patient-level factors, access to kidney transplantation varies by race, sex, and income.

In terms of longitudinal trends, between 2002 and 2007, we see that the rate of kidney transplants increased for Asian Americans and Native Americans, remained about steady for African Americans, and decreased for whites. We will continue to monitor trends in this area as well as new research and report back to you once new data are available.

Here is the second new piece of information we have to share with you. This is the Medicare margin for 2008 by provider type. You can see it varies across the different provider types. It was larger for the largest two dialysis chains than for everybody else, and this is linked

to economies of scales. For rural facilities it is a bit lower than zero. We think this finding may be linked to two factors. First, the phase-in of the changes in the ESRD wage index and the decrease of the wage index floors. Second, the volume of erythropoietin stimulating agents -- that is, EPO and Aranesp -- declined overall but, in particular, for the two largest dialysis chains, and they account for a greater proportion of freestanding facilities in rural areas than other freestanding providers.

The decline in the volume of erythropoietin stimulating agents is not surprising. It is linked to continued clinical evidence that suggests that patients with chronic kidney disease are at increased risk for cardiovascular events when they receive higher doses of these drugs.

We are concerned about the direction of margins for rural facilities. That being said, under the new payment method that begins in 2011, a low-volume adjuster will be implemented. This is mandated by law. Under CMS' proposed rule, rural facilities will disproportionately benefit from the low-volume adjuster, and for those rural freestanding facilities that receive payments through the

low-volume adjuster, payments will increase by an average of 12 percent.

So, to summarize, this is the first year we have seen this type of drop for rural facilities. We will continue to watch their margins and report back to you next year about the direction. In addition, because of the critical importance of ensuring benefit access to dialysis, we will be putting some additional thought and study into this subject.

To summarize the information that I presented about payment adequacy in December, overall our adequacy indicators are positive. The supply and capacity of providers is increasing as measured by the increasing number of facilities and dialysis stations.

Beneficiaries' access to care appears to be good. There is little change in the mix of beneficiaries providers treat. For example, the demographic and clinical characteristics of beneficiaries treated by freestanding facilities did not change between 2007 and 2008.

In terms of volume of services, we see that the growth in dialysis treatments matches beneficiary growth. Looking at the volume of dialysis drugs, as I previously

noted, we did see a decline in the volume of erythropoietin stimulating agents. We are not surprised by that, again, based on the new clinical evidence available. We do see, though, that other dialysis drugs, the volume continues to increase.

In terms of quality it is mixed. Some measures are high or improving, like dialysis adequacy and the use of AV fistulas for vascular access. Other areas need improvement, including, as we've discussed, kidney transplantation, and rates of hospitalization and mortality remain high.

Access to capital appears to be good, as suggested by independent investor analysts, as well as the continued growth in the sector.

The projected Medicare margin for 2010 is 2.5 percent. This projection reflects the 1-percent composite rate update in 2009 and 2010. Our projection assumes that providers' costs will increase more than the composite rate update. Our projection does not take into account the 2-percent budget neutrality provision that is mandated under MIPPA and that will begin in 2011 with the phase-in of the new dialysis payment method. The biggest reason we did not

include this provision is that it is very unclear how providers' will react to the new payment method. We would expect that providers will become more efficient particularly in the provision of services that are now currently billable under Part B, including dialysis drugs.

The evidence on payment adequacy suggests that a moderate update of the composite rate is in order and that dialysis providers can achieve efficiency gains similar to the economy at large. The draft recommendation reads that the Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less the adjustment for productivity growth for calendar year 2011. The current value of the market basket is 2 percent, so this draft recommendation would update the composite rate by 0.7 percent.

In terms of implications, this would decrease spending relative to current law between $50 million and $250 million in 2011 and by less than $1 billion over five years. And in terms of beneficiaries, it would lower their cost sharing relative to current law.

MR. HACKBARTH: Okay. Thank you, Nancy.

Clarifying questions, beginning with Herb.

MR. KUHN: Just a quick question, Nancy, on the use of ESAs. I think I read a couple weeks ago where FDA is now beginning a new look into this area. Do you have any more information of what they're looking at or how long this investigation might take with FDA now?

MS. RAY: I don't. The only piece of information that I know is what was in the -- there was an article in the New England Journal of Medicine that suggested that they are planning on holding a public advisory meeting about the use of ESAs among chronic kidney disease patients, and particularly -- I know that the article discussed the need for more clinical trials that would try to better look at the target hemoglobin levels. I know they raised concern about 13 as the target hemoglobin levels, as well as the oscillation in the dosage of ESAs.

MR. KUHN: I guess I was just curious if we think or based on information that anybody has seen thus far, the last time FDA did a hard look at ESAs, it led to a new national coverage decision by CMS for oncology services. We don't know if that's the direction where this ultimately could lead. That would be pure speculation, I would assume.

MS. RAY: Yes.

MR. KUHN: Okay. Thanks.

MS. RAY: But also to make a point, CMS did revise its ESA monitoring policy for dialysis as well, first, I believe, in 2006 and then again in 2007. So that has also kept up with the FDA evidence.

MR. GEORGE MILLER: First of all, I've got a question about Slide 3 and certainly appreciate the effort to get this information and provide it for me and the Commission. I'm very pleased that transplants increased for Asian Americans and Native Americans. I'm concerned that for African Americans it has not increased and want to know if you have any of the reasons why it hasn't. And I'm a little bit concerned it declined for whites. I'd like to know the reasons. Obviously, the goal is to maintain the increase in each one of the segments, not for them to go down. And then, what can be done to increase transplants across the spectrum of every American who has -- but I'm real concerned about the fact that 32 percent of African Americans are getting end-stage -- have end-stage renal disease but yet don't get -- the percent is very poor for kidney transplants.

MS. RAY: Well, the more I get into this area, the

more I see that it's a very, very complicated area to get into. I think kidneys are a scarce resource, and there certainly are not enough for the demand. So I guess I wasn't completely surprised to see an increase for one group with a decrease for another group. That being said, I definitely would like to do more study about that trend.

With respect to the decline for whites, there was, at least in the recent two years, a decline in the -- so this is between 2006 and 2007, to be clear, a decline in -- the live donor procedures declined more than the cadaver procedures. That being said, you know, I think we need to -- that's just a one-year drop, and we need to see, you know, what develops.

MR. GEORGE MILLER: I think that's a good point. Wasn't that the case with African Americans also in the chapter that the percentage of live donors versus cadaver donors, which is much lower among all groups, if I remember reading correctly?

MS. RAY: Right. If you're talking about the split in -- if you're looking at all transplants for African Americans, I believe that what the numbers suggest is they tend to get more from cadaver than from live donors. And so

that's another reason for the difference that we see in the rates. But, again, this is such a complicated area and there's such a lot of different factors affecting what we're seeing that I think I would feel a little bit more comfortable studying this a little bit longer and then coming back to you.

MR. HACKBARTH: Other clarifying questions for Nancy?

[No response.]

MR. HACKBARTH: Nancy, can I just ask you about Slide 4 for a second? In talking about the difference between the two largest chains and others, you said economies of scale were a factor, and I just wanted to pursue that a little bit further. Is it economies of scale in running dialysis facilities, or is it purchasing power in buying drugs, that the big chains have much more power and, thus, lower unit prices, or some combination?

MS. RAY: Some combination of both.

MR. HACKBARTH: Is there any way to try to disentangle those two?

MS. RAY: I mean -- yes. Yes. I think the --

MR. HACKBARTH: I think it might have different

implications, and so we don't need to go into it now.

MS. RAY: Right, right.

MR. HACKBARTH: But maybe we could talk about it later.

MS. RAY: The cost report data is complex in doing that, though, because of where some administrative costs are put, and so that's where my hesitancy comes from.

MR. HACKBARTH: Okay. Well, we can talk some more about that. And then a question about the urban/rural, and maybe I just missed it in your presentation. Wasn't there also an issue with a wage index floor for the rurals?

MS. RAY: Yes.

MR. HACKBARTH: And would you just explain that a little bit more?

MS. RAY: Yes, yes. Beginning in 2006, CMS has started to lower the wage index floor. In 2005, it was 0.9, and so beginning in 2006, it has been lowering it year by year. So that has resulted in some change, yes.

MR. HACKBARTH: And then when we transition to the new payment method, there won't be any wage index floor, but there will be a low-volume adjustment.

MS. RAY: That's what CMS has proposed.

MR. HACKBARTH: Okay.

MS. RAY: That's correct. CMS has proposed for the broader bundle to do away with the wage index floor and to continue to phase out the floor for those facilities that don't completely opt into the new payment method.

MR. HACKBARTH: Okay. Round 2 comments on dialysis?

[No response.]

MR. HACKBARTH: We are ready to vote. Would you put up the recommendation, Nancy? All in favor of the recommendation, please raise your hand. Opposed? And abstentions? Okay. Thank you.

Next is skilled nursing facilities.

DR. CARTER: Okay. I want to start with a thumbnail sketch of the industry. SNFs furnish services to about 1.6 million beneficiaries. In 2008, Medicare spent about $25.5 billion on these services. There are just over 15,000 providers, and most of them are also nursing homes. Medicare pays providers for a day of care using 53 case mix groups.

Last month, we considered the adequacy of Medicare payments using our standard update framework. I'll briefly

review that information and the draft recommendation. Several of you asked for additional information which I've tried to incorporate where possible.

The indicators we examined suggest that payments are more than adequate. Our measures of access indicate that access is adequate for most beneficiaries. Supply has been fairly stable for several years, and volume -- in terms of days and admissions -- has increased between 2007 and 2008. As we discussed last month, access for two groups of beneficiaries warrant further examination -- minorities and patients with medically complex conditions.

Quality has increased slowly, and access to capital has improved from last year but is restrained due to factors unrelated to the adequacy of Medicare payments. A comparison of payments and costs indicate that Medicare payments are more than adequate.

Bill, you asked about the geographic patterns of minority beneficiaries, SNF users, and SNF beds, and we will add that to future analyses but didn't have time to do that for this month.

Mitra, you asked about whether minorities are concentrated in medically complex case mix groups.

Here you can see we found that minorities do make up a larger share of medically complex admissions compared to therapy and all admissions. On this slide, African Americans are shown in the middle group. They made up 16 percent of medically complex admissions -- the last bar, the one in red -- compared with 10 percent of therapy and total admissions -- that's the yellow and the green bars. Last month, I reported that fewer SNFs admit medically complex patients than admit rehab patients. Therefore, minorities could face delays in placement because they make up a larger share of medically complex patients. CMS plans to make changes in 2011 to the case mix groups that will improve the payments for these patients. Your standing recommendation to target payments for non-therapy ancillary services such as drugs would further improve payments for these patients.

Two trends in service use underline the need to revise the SNF PPS. First, the concentration of medically complex cases in fewer SNFs indicates the need to better target payments for non-therapy ancillary services and to base therapy payments on patient care needs, not service provision. Second, the large increase in the intensity of rehabilitation services reflects the financial incentives to

furnish therapy services and the payment biases in the current PPS.

You'll recall that, while budget neutral overall, your recommended changes to the PPS would redistribute payments from rehabilitation stays to medically complex stays. As a result, payments would increase for facilities with high shares of medically complex cases and those with high non-therapy ancillary costs. And it turns out that these are disproportionately facilities with low margins, hospital-based units, and nonprofit SNFs.

Turning to our analysis of margins, the aggregate Medicare margin for freestanding SNFs was over 16.5 percent for 2008. This was the eighth year in a row that freestanding facilities had aggregate margins exceeding 10 percent. Like other sectors, there is wide variation in the financial performance, which you can see on the slide. This variation would partly be addressed by the recommended changes to the PPS. Payments to hospital-based facilities, for example, would increase 20 percent, and payments to nonprofit facilities would increase 7 percent.

George, you asked about the impact of hospital-based units on hospitals with SNFs. Past interviews with

hospital administrators of hospitals with SNFs revealed that they think about their SNFs in the context of how these units complement their inpatient business. They told us they look at the SNF's impact on their inpatient margin, the inpatient length of stay, and whether the unit helps free up inpatient space to treat other patients. In recent conversations, you've mentioned that this is how you think about hospital-based SNFs as well.

We also looked at 2008 hospital data to see how inpatient margins compare for hospitals with and without SNFs, and we found that hospitals with SNFs have inpatient margins that are at least one percentage point higher than hospitals without SNFs.

We estimate that the Medicare margin for freestanding SNFs in 2010 will be 10.3 percent. We think this projection 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 may increase payments.

Tom, you asked what we knew about the differences between high- and low-margin SNFs, and I'll go over that.

Compared with low-margin SNFs, facilities with high Medicare margins had much lower total, ancillary, and overhead costs -- 25 to 30 percent lower. They also treated a more profitable mix of patients, with higher shares of intensive therapy days and lower shares of the medically complex days. These SNFs had higher daily censuses (over which to spread their fixed costs) and were much more likely to be for-profit.

Turning to our analysis of "efficient" SNFs, we examined SNFs with low costs and high quality. After multiple years of average margins above 10 percent, it is not clear if we have identified facilities that are actually efficient since there is little Medicare pressure to be so. That said, when we examined relatively efficient SNFs, we found that they had costs that were 15 percent lower and quality measures that were 20 to 40 percent higher than other SNFs. Relatively efficient SNFs were disproportionately nonprofit, more likely to be rural, and smaller. Their Medicare margins were considerably higher than other SNFs indicating that it is possible to have well-above-average financial performance and provide high quality of care.

This leads us to the draft recommendation. The Congress should eliminate the update to payments for SNF services for fiscal year 2011. Our rationale is consistent with 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 to $700 million for 2011 and by $1 to 5 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 update recommendation as part of the SNF package of recommendations that together consider the level and distribution of payments. The update recommendation addresses the level of payments and aggregate spending, while the recommendations to revise the PPS are key to redistributing 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 raise and lower payments based on outcome measures such as rates of rehospitalization and discharge to

the community. We plan to re-print these previous recommendations in the front of the chapter, like Glenn talked about this morning.

And with that, I'll put up the draft recommendation.

MR. HACKBARTH: Okay. Round one clarifying questions.

DR. STUART: Let me see if I can get this right about the relationship of margin and having an inpatient SNF. I thought you just said that if you have an inpatient SNF, then your profits are higher than if you did not have an inpatient SNF. Is that overall Medicare margin?

DR. CARTER: No. It's the inpatient margin.

DR. STUART: The inpatient margin.

DR. CARTER: So it helps you manage your inpatient business.

DR. STUART: Okay. So your inpatient -- but did you look at the overall margin?

DR. CARTER: We saw that this morning during the hospital, right? -- well, not merely just SNF, but that --

DR. STUART: Well, that's what I'm trying to get at, because if the SNFs, in fact, do improve overall margin

and they reduce -- even if they lose money, if they lose less money on the SNF side than they make up on the inpatient side, then overall they're profitable. We're going to come up against a number of these post-acute providers, and in most of them, I think we're recommending zero updates because the profit margins seem adequate enough across the board. But then we come back, and we saw that slide earlier that said that when you add all of these other factors together, then the overall Medicare margin drops. So it's just trying to get this thing in my head.

DR. MARK MILLER: Well, and just to go through this again, when you have those other lines of business collectively, the margin moves, you know -- is, you know, a point or less than a point worse overall.

The second point that we made this morning and made just now -- and this triggers off of some comments over here George and some other people have made of, well, particularly -- you know, using the hospital-based SNF as the example, people tend to think of that as complementary to their inpatient line of business. And when you look at the inpatient margin, that is actually better in the presence of a hospital-based SNF.

So the hospital-based SNF can be -- there's a question about the cost allocation there, but putting that aside, be negative in and of itself, the hospital-based SNF. But when you think about it in the present -- the inpatient margin in the presence of that, the inpatient margin is better.

MR. LISK: We also looked, though, at the overall Medicare margin with SNF and without, and actually the overall Medicare margin is a little bit higher for hospitals that have a SNF compared to hospitals without.

DR. STUART: [off microphone].

MR. LISK: Yes.

DR. STUART: Then how important is the SNF to the contribution of the overall margin across all hospitals compared to other post-acute services? Because what you just said goes against what we saw earlier in hospitals.

MR. HACKBARTH: I think what Craig is pointing out is if you look at the overall margin, that includes the hospital inpatient, the hospital outpatient, hospital-based SNF, hospital-based IRF and so on, that total margin is lower than the inpatient alone. So all of the other services in combination tend to pull down.

Now, the degree to which those other services help the hospital on the inpatient side varies, and what I hear Craig saying is that in terms of helping a hospital manage its inpatient costs, SNFs have a particularly strong effect. So if you just isolate hospital-based SNF, that can help a hospital considerably in terms of managing inpatient costs. The effects for the others are weaker or even on net negative.

MR. LISK: You have to remember the margin goes down when you add in those other services in there, just as the performance actually with a SNF, actually hospitals perform a little bit better on average.

MR. BUTLER: Okay. So along those lines, the data is what it is, and I would agree that you look at this in a complementary way, but most institutions are not reaching the conclusion that there's an overall positive impact because they're getting out of these businesses. So the data is what it is, and I would like to know if it's so helpful on the inpatient side, can anybody name a hospital that has started a SNF, a hospital-based SNF in the last couple of years? Because if you really knew your numbers, you'd see this being put in place as an overall positive

impact, and I can't name anybody that's done that.

MR. HACKBARTH: Nor can I --

DR. CARTER: But I did look at that.

MR. HACKBARTH: Nor can I, and I think that's a good point. It also --

MR. BUTLER: We're not stupid. We'd do it if we felt it was overall coordinating the --

MR. HACKBARTH: Wait. I'm going to quote something that I heard from somebody I really trust, and it's Peter. Actually what you would look at is the alternative uses of that same capacity, and if you could use that same capacity to produce -- use it for even higher-margin lines of business, you might say, oh, a SNF can marginally help us on the inpatient side, but if we use that building capacity to expand our cardiology unit, we can make even more profit.

So the mere fact that hospitals are not adding SNFs in and of itself does not belie Craig's statement, not in the business world that I used to operate in.

DR. MARK MILLER: The only other thing I would say is a couple years ago, we -- you know, this issue has come up times before, and so in addition to sort of looking at

the data, we went out and talked to hospitals and sort of identified different models and roles for, you know, hospital-based SNFs, like how do you guys think about this, and went to different models and kind of identified different strategies that people use.

But the other thing that came out of the work -- Corbin Liu did this with us at that point in time, if people remember him. At that time people were actually -- there were a few people who had made the decision, even though the trend was decidedly get out of this business, who were opening a hospital-based SNF for the reason that we're making -- the point that we're making here. I don't mean to overstate this. This was decidedly not the trend, but that we were going to hospitals that actually said, okay, we're opening one because, and it was kind of this inpatient line of business, thought process.

MR. HACKBARTH: And I think the other thing that has happened in recent years that has an effect here is the transfer policy and tightening up of transfer policy, which I think -- and tell me if I'm wrong here, Craig -- the tighter transfer policy as of several years ago reduces the value of the hospital-based SNF in managing inpatient costs,

because if you're aggressively moving patients out of inpatient into the hospital-based SNF side with short lengths of stay, Medicare has now started to reduce the inpatient rates accordingly. So there are lot of things going on here, I think.

DR. CARTER: And I did want to just add one fact to this.

MR. HACKBARTH: I'm sorry.

DR. CARTER: Of the 108 new facilities that opened between 2008 and 2009, six were hospital-based, so that's about 5 percent of the industry, which is about where they are in the industry overall.

MR. HACKBARTH: I should have let Carol go -- I rudely interrupted when she first started to speak, and she had the answer for you all along.

[Laughter.]

DR. KANE: Two questions. One, what proportion of hospitals have SNFs?

DR. CARTER: Well, there are about 700 hospital-based SNFs, and depending on -- are you talking about PPS hospitals?

DR. KANE: Yes, so maybe --

DR. CARTER: 20 percent?

DR. KANE: Because it is hard to understand all these numbers that are -- you know, some include all lines of business, some include -- it would be helpful in the future if the hospitals with hospital-based SNF margin could be calculated, just so we can -- and then the total -- and then the hospital in, out, and SNF margin could be calculated, just to sort of get us past getting hung up on this, I think that would be helpful.

The question was what have -- we have been recommending zero updates. What have been the updates for the last three or four years?

DR. CARTER: They have been getting market basket.

DR. KANE: Market basket without even a productivity adjustment.

DR. CARTER: Right.

DR. KANE: And is there some obvious reason for that, or it's just --

DR. CARTER: It's the law. I mean, they've been doing what they've been legislated to do.

DR. KANE: So they are getting full market basket.

MR. HACKBARTH: Yeah, and I think one of the

reasons for that is that the SNFs, as you know, have been urging us and the Congress to look at total margins, including the Medicaid business, which are lower. And while we have insisted that the sensible thing to do is to focus on the Medicare margin, because using Medicare dollars to try to offset Medicaid shortfalls doesn't make good sense for reasons that, you know, we've gone through multiple times. The Congress has not necessarily gone along with that, and they've tended to give higher updates to help offset Medicaid. That's at least one of the reasons.

Round one.

DR. SCANLON: This is a little bit of round one and a half. I mean, there is the question here, and the question is, What is a hospital-based SNF? Because I know of hospitals where they own a SNF which is miles and miles from the hospital. And from a CMS perspective, does that get counted as hospital-based or is that an independent SNF? One of the problems I know we've had with nursing homes in the past is being able to link ownership and get chain information.

The other thing, which is more of a comment, is I don't think that we really can fully understand what the

realities are from the numbers that we've seen, particularly sort of the numbers where we said when we added in sort of post-acute services to the hospital and we've combined sort of hospitals that have them and hospitals that don't. The decision that a hospital is going to make -- and I am projecting, even though I've never worked for a hospital -- is what it would have been if we didn't do this, not what it is -- I mean, in a measurable sense in terms of this is what our prior experience is. And so I think it goes back to what we talked about physicians. It's very, very sort of idiosyncratic in terms of the markets you're in. What's your ability managing inpatient care to place people when you could into a SNF that is going to provide them sort of adequate services? And if the market is such that that's not a problem, then your calculation is very different than if you know that you're going to be stuck with these people, they're not going to be able to be discharged, you're not going to get any additional PPS payment except for sort of limited outlier payments, and, therefore, you think about it's much better to have the SNF take losses, but I have an increase in revenue.

MR. HACKBARTH: Carol, do you want to address

Bill's first question about how it would have a freestanding, separate, miles-away facility owned by the hospital count as a hospital-based SNF or is that counted as a freestanding --

DR. CARTER: I don't know, expect that they would be on the -- if they're in the hospital cost report, then they're considered hospital-based, and that's how we count them.

DR. SCANLON: Right. But it's possible that they aren't on the hospital cost report, right? I mean, because we've got hospitals and then we've got holding companies.

MR. LISK: If it's part of the hospital corporation, it would generally be on the hospital cost report. There was an example at one place we went and visited. We thought that they had the hospital-based SNF -- we thought we were visiting a hospital-based SNF because of its name and some other things. In fact, the hospital did have a hospital-based SNF, but it was actually 35 miles away. So they had none of their patients actually going there.

So when we talked about, let's say, the models of the hospital-based SNFs, we kind of had three different

models. There's ones that operate just like regular freestanding nursing homes in terms of what they look like, and sometimes they may not be -- they're connected to the hospital. And then there's the ones that were connected to the hospital that were operating more as subacute care units. And then there are ones that are operating kind of like dealing with rehab patients and dealing with that line of business. We kind of had those three models that we outlined in our report several years ago and stuff. But that's kind of what kind of happens. So there can be -- there's many that look like freestanding, and their margins are higher relative to the hospital-based ones when you look at those kinds, when we factor those different types of SNFs into play.

MR. HACKBARTH: Round one.

MR. GEORGE MILLER: I was very pleased with Slide 5 that talked about minorities make up the largest share of the medically complex. Do you have a similar demographic on patients that get therapy, the demographic make-up of those who get therapy? Because it seemed to be quite a bit of cost difference between those who get therapy, the payments are higher, versus medically complex.

And a second question, still a round one question, but you identified what would be a more efficient SNF and thereby the cost is 15 percent lower. Do you know what percentage of complex patients those more efficient SNFs would have?

MR. GEORGE MILLER: Is it the same percentage of all the other SNFs? Is it lower? Is it higher?

DR. CARTER: Yeah, yeah, I understand the question. I'm looking to see whether I calculated that, and I don't see that in here, and it's possible I have it back in the office, but I don't have it with me.

And then your other question about -- you asked about racial make-up of therapy --

MR. GEORGE MILLER: Patients, yes.

DR. CARTER: So they make up -- I think that's on this slide, right? It's the green bar. So they make up 10 percent of therapy cases.

DR. CARTER: 10 percent

MR. GEORGE MILLER: Why would that be? Why would there be such a huge disparity in African Americans and other Americans getting therapy versus whites?

DR. CARTER: You mean why are more --

MR. GEORGE MILLER: Am I reading this correctly?

DR. CARTER: It's the mix of all patients, right? So they make up 16 percent of medically complex --

MR. GEORGE MILLER: And they only get 10 percent of the therapies.

DR. CARTER: And 10 percent.

MR. GEORGE MILLER: So I'm reading it right.

DR. CARTER: Right.

MR. HACKBARTH: I think, George, the way to look at the African American columns is that they represent 10 percent of all patients, but they're 16 percent of the patients receiving -- that are medically complex. So African Americans are disproportionately represented among medically complex.

If you look at the white column, whites represent 85 percent of all patients, but only 80 or less than 80 of the medically complex, so they're underrepresented.

MR. GEORGE MILLER: I got it.

MR. KUHN: Therapy, they're almost even --

MR. HACKBARTH: And therapy -- yes.

MR. GEORGE MILLER: I got it. All right. But that doesn't explain the medically complex.

MR. HACKBARTH: No.

MR. GEORGE MILLER: Got it. Therapy is not the issue.

MR. KUHN: A quick question on the high-margin SNFs. I was interested about the characteristics of the more profitable mix of patients and the intensive therapy days, and that was pretty clear. I'm curious also in terms of was there any characteristics of SNFs -- because many of them are dual licensed for long-term care as well as skilled nursing, and obviously we have a mix here of kind of the services, whether it's medically complex or intensive therapy. Is there any characteristics in terms of mix of payers, like 20 percent of the patients would be SNF, 80 percent would be long-term care? Is that an indicator that's worth looking at as well?

DR. CARTER: I didn't look at that. I understand the question, but I didn't look at it. So you're asking sort of what share of the total facility is SNF as opposed to nursing home care?

MR. KUHN: Right.

DR. CARTER: I haven't looked at that.

MR. KUHN: Okay. Thanks.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: Okay, round two comments.

MR. BUTLER: Actually, I'd support the recommendation, and despite the negative margins in the hospital base, the fact is -- and we've pointed this out, I think, before -- that it's not just the salary levels that are higher -- I'm thinking of ones that are physically in the same institution versus the freestanding. If I were to set up a system of care, except capitation, and have the components of care, I'd be a big proponent of having a freestanding skilled nursing as an important part of managing the care. When it's in the same facility, I find it's very hard to manage it at an arm's-length way so that you both have the lower salaries and the culture. You typically would put it under the same head of nursing will say, well, we've got to have these staffing levels, we've got to have these kinds of things, and even the physician and medical direction tends to kind of trickle over into that hospital base so that you are even practicing a little bit of the inpatient kind of medicine on that unit, which makes it expensive. It's good, but it is more expensive

than a freestanding would be, whether it's under the umbrella of, you know, technically hospital-based or not.

So, you know, I'm not thinking that we should be making up these inpatient rates rapidly for this particular area, so for those kinds of reasons I'm supportive of the recommendation.

DR. CASTELLANOS: Page 8, I look at that slide, and my first comment was, "I'm in the wrong business." Those margins are pretty high.

DR. KANE: Instead of an ASC, do you want to run a nursing --

DR. CASTELLANOS: Those are high margins, and I know we made some previous recommendations to revise the PPS and to adopt a pay-for-performance. Where do we stand with those recommendations?

DR. MARK MILLER: We made two sets of recommendations. One is on adjusting the payment for complex medical care patients relative to therapy because we think that the payment system is incenting the therapy and that some people are tracking to that line of business. Those changes would rebalance that out, and as I understand it, they are included in the House bill, or a good piece of

them are included in the House bill and still in play. And, of course, they're reconciling between the two bills.

DR. CASTELLANOS: Okay.

DR. MARK MILLER: On the pay-for-performance stuff, we've made that recommendation -- you seemed to want to get into this -- but I'm not sure that -- so I'll stop if you want me to.

[Laughter.]

MR. HACKBARTH: I'll tell you when you are doing bad.

DR. MARK MILLER: Again? I'm not aware that that's included in any legislation. I'm not aware that that's in any of the legislation.

DR. CARTER: Yeah, I think both for the House and Senate, both have -- require CMS to come up with a plan for value-based purchasing.

DR. MARK MILLER: I see.

DR. CARTER: But CMS has a demonstration underway for nursing home pay-for-performance that started this past summer.

MR. HACKBARTH: What I was going to ask was that my recollection is on SNF pay-for-performance, our views

underwent some evolution, and a couple years ago, three years ago, we recommended that the focus be on sort of outcome measures, discharged to the community and readmission to hospital as opposed to some of the softer measures that are included in, for example, the CMS website. Is that correct?

DR. CARTER: Well, and some of those measures are probably better measures for long-term care patients, things like pressure sores.

MR. HACKBARTH: Right, and that was the rationale, was to really focus the Medicare measures on the skilled population.

DR. CARTER: Right. And the demonstration has both sets of measures.

DR. CASTELLANOS: I guess my question is, if this falls through the cracks, has there been any discussion on -- like we're going to be discussing a little later this afternoon about rebasing --

MR. HACKBARTH: Well, you know, that's something we can come back to and take a look at. One of the reasons from my perspective for focusing on home health is that we see some different characteristics between the home health

marketplace and SNF marketplace. SNF, the supply is relatively constant, growing slowly, in some areas there may even be issues about getting access to skilled nursing beds. Whereas, on the home health side, generally speaking, setting aside some areas of the country, we've got rampant growth, rapid entry. And so between the two high-margin areas, it seemed to us that home health -- it seemed to me that home health was a much more pressing sort of problem.

DR. CASTELLANOS: Thank you.

DR. MARK MILLER: There was also just a little bit more of evidence which just made it easier to analyze the issue where you could track sort of the count of the visits that were used to construct the episode and the count of visits that actually were being delivered under the episode. But this is not no. I mean, we can continue to think about this. It won't be this afternoon. I do want to be clear about that. But we can think about this.

MR. HACKBARTH: Other comments?

MS. HANSEN: Yes, I'm supportive of the recommendation, and earlier this morning I asked about just how -- with the realignment of making sure some payments go toward complex individuals, and I had some concern about

that on the part of just the volume side of doing it well, for example, if you only had a few. But, Peter, just a light bulb came on for me when you said that. I can see why hospitals, you know, wouldn't do it because the culture and the pattern and the staffing and the operation is so much the same that the kind of style would be better done in a very focused group of, like, a stand-alone, if that was the case to be able to focus on it well. So that actually made sense, but I just would hope that how those nursing homes would get funded, they'd be funded adequately to deal with the complexity with the kind of competence that was needed.

So I just wanted to close the loop on that because I was thinking originally of seeing whether that 20 percent added pay would make that difference for the hospital side, and it's not just the money, it's really the whole cultural way that a hospital would operate as compared to something that would be freestanding. So I just wanted to pull that back from an earlier comment I made today.

DR. CARTER: I just wanted to add that CMS in the new case mix system that it plans to implement this fall has, I think, 13 or 16 new case mix groups that are much more focused for medically complex patients. So I think

that will help also in directing payments for these medically complex patients. But that said, I took your comment very seriously about how do you ensure competency in sort of hiring and reducing turnover and the chronic issues in this sector.

MR. HACKBARTH: Okay. Before we vote, I just want to go back to Nancy's question about why the Congress has given full market basket updates, and, you know, I explained I thought part of the reason probably had to do with Congress being sympathetic with the argument made by the industry that you ought to focus on total margins, including Medicaid, as opposed to just Medicare, as we do. And for the benefit of the people in the audience who haven't heard me talk about this before, it just occurs to me that I ought to explain our thinking there.

If you try to offset low Medicaid payments by more generous Medicare payments, there are a number of potential bad side effects, but let me focus on two.

Number one is that the skilled nursing facilities that would benefit most from such a policy are, by definition, those that have the highest proportion of Medicare patients and the lowest proportion of Medicaid

patients. So the biggest checks go to the ones who actually have the fewest Medicaid patients. So it's a very poor system of targeting money to the institutions presumed to be in need.

A second problem is that if the federal government says, Well, we take responsibility for the bottom line of institutions, which, after all, are primarily Medicaid -- Medicare represents 12 percent or something like that, on average, of the patients -- then, in effect, the federal government has said to the states, go ahead, you know, feel free, you have a license to cut your Medicaid payment rates to SNFs because we're responsible for the bottom line, and we'll just keep bumping up our payment rates to the 12 percent to offset your costs. And that is, you know, inconsistent with the basic design of Medicaid and sharing between the federal government and the states.

There are some other issues as well, but those are our two principal reasons for thinking higher Medicare rates is not a good way to deal with low Medicaid payment.

Okay, time to vote. Would you put up the recommendation? All in favor of the recommendation, please raise your hand? Opposed? Abstentions?

Thank you, Carol.

Okay, next is inpatient rehab facilities. Kim, are you going first?

MS. NEUMAN: Yes. Good afternoon.

We will now turn to payment adequacy for inpatient rehabilitation facilities. Craig and I are going to summarize our findings concerning supply of providers, occupancy rates, volume of services, quality, access to capital, and margins.

Before doing that, though, we would like to thank Jae Yang for his substantial work on the analyses in this presentation.

Also, before turning to payment adequacy, I'd like to address a question from the December meeting. Herb, you asked whether many providers had lost their IRF status due to the compliance threshold.

As you all will recall, the compliance threshold requires a certain percentage of IRF patients to have one of 13 diagnoses in order for a facility to be paid as an IRF. In 2004, CMS began phasing in this percentage with the ultimate goal of it reaching 75 percent. But in late 2007 Congress permanently set the threshold at 60 percent.

Since the threshold has been 60 percent, only two out of roughly 1,200 IRFs have lost their status due to noncompliance.

So, now for a quick overview of IRFs. As you know, IRFs provide intensive inpatient rehabilitation services such as physical, occupational, and speech therapy. Over 332,000 fee-for-service Medicare beneficiaries were admitted to about 1,200 IRFs in 2008, with Medicare spending exceeding $5.8 billion dollars.

As we discussed in December, our indicators of payment adequacy for IRFs are generally positive.

In terms of the number of providers: the number of IRFs was stable in 2008, unchanged from the 2007 level.

Looking at occupancy rates: We see IRF occupancy rates had been on a downward trend throughout the decade, until 2008 when they increased slightly. The 2008 occupancy rate still remains below levels earlier in the decade.

The stable supply of IRFs and relatively low occupancy rates suggest that the supply of IRFs is adequate to meet demand.

In terms of the volume of Medicare FFS patients served by IRFs: after a sharp decline in FFS patient volume

from 2004 to 2007, the decline in volume tapered off significantly in 2008, decreasing by less than 1 percent. The volume declines in earlier years reflect changes in IRF admission patterns to meet the compliance threshold.

For example, as demonstrated in this next slide, IRFs have significantly reduced their admissions of hip and knee replacement cases which generally do not count toward the compliance threshold. There have been questions of whether this decline in volume constitutes an access problem, but our analysis of hospital discharge patterns suggest that such patients are receiving care in other settings, such as home health and SNFs.

In terms of quality, we have seen that functional gain between IRF admission and discharge has increased in each of the last five years. While this may suggest an improvement in IRF quality, we cannot conclude that definitively because IRF patient mix has changed substantially over this period and our data are not risk-adjusted.

We have contracted with RTI to analyze risk-adjusted functional gain and other potential quality measures, which we anticipate will help us better measure

trends in IRF quality in the future.

With respect to capital, credit markets have begun to ease relative to the credit crisis of 2008 and are operating in a more normal manner. Hospital-based IRFs, through their parent institutions, and chains of freestanding facilities exhibit continued access to capital.

Now, I'll turn it over to Craig to discuss margins.

MR. LISK: In 2008, the aggregate IRF Medicare margin was 9.5 percent. This slide shows a breakdown of IRF margins by different categories of providers, in which you can see there is substantial variation in IRF margins across providers and the different types of IRFs.

Freestanding and for-profit IRFs have the highest margins. Hospital-based IRFs and non-profit IRFs have comparatively lower margins. Urban IRFs have somewhat higher margins than rural. And to remind you, the Rural IRFs receive a 20 percent add-on payment under the IRF PPS.

Margins also vary by the size of the IRF, with smaller IRFs having the lowest margins and the larger IRFs having the highest. This relationship is seen within the different IRF groups, including hospital-based and

freestanding, and urban and rural IRFs. In fact, actually, if you look by bed size, rural IRFS have slightly higher margins than urban IRFS if you control for bed size.

Interestingly, we also see that smaller IRFs -- if we look at occupancy rates -- smaller IRFS actually have lower occupancy rates than the larger IRFs. If you look at the hospital-based IRFs, the average occupancy is 67 percent in units with 60 or more beds and 51 percent in IRFs with 10 or fewer beds.

This next slide shows our project margin for 2010. We have modeled our IRF margins using 2011 policies except for the update and project a margin of 5 percent. In projecting this margin, we take our most recent available data and then consider the policy changes that have taken place between 2008 and 2010.

In this analysis, we took account of the rates in 2009 being held to 2007 levels, and a technical outlier adjustment that was made in 2009. We also accounted for the market basket level update IRFs received in 2010. We also assumed that costs would rise at market basket.

Taking all of this into account, we project a margin of 5 percent in 2010. The projected decrease in

margin is driven almost entirely by hospital rates being set at 2007 levels in 2009, a provision that was enacted under MMSEA.

If IRFs react to these payment provisions by holding down cost increases below the market basket rate of increase, due to the financial pressure of these lower payment rates, we would expect the margins to be higher than the 5 percent we project. In the past, we have seen that IRFs have been able to control their cost growth when placed under financial pressure, such as when the IRF PPS was first implemented and the uncertainties created by that new payment system.

So with that, we will move on to the Commission's draft recommendation which is based on your discussion from the last meeting. The recommendation reads: the update to the payment rates for inpatient rehabilitation facilities should be eliminated for fiscal year 2011.

The spending implications are that it would decrease program spending relative to current law by $50 million to $250 million over one year in 2011 and by less than $1 billion over 5 years.

We see no adverse impact on beneficiaries. We do

see increased financial pressure -- we do see that there may be some increased financial pressure on some providers, but overall a minimal effect on providers' willingness and ability to provide care for Medicare beneficiaries.

And with that, we would be happy to answer any questions you may have and look forward to your discussion.

MS. HANSEN: This is a clarifying question and I don't know why, in the course of reading this, it struck me more here than other segments or lines of Medicare business. But this is fee-for-service reporting of services, but when you have health plans who want to have IRF services for their enrollees, how does that get captured in terms of any of this here?

MS. NEUMAN: In the data we have, we're looking at only Medicare fee-for-service beneficiaries. You know, from talking to folks about how the private sector does this, I think in general the model in the private sector is a per day payment rather than a per discharge payment. So it's a little bit of a different model.

We don't have data on how that all falls out, but it is a different approach.

MS. HANSEN: It struck me, having also been on the

purchase side when I was purchasing services -- I paid per diem, as well. So that was kind of my normal rate.

But I just wonder how that affects the operations of these entities, whether it's home health -- it could be any segment. But it just struck me as what impact that has on any of these lines of business, in terms of the proportionality of a capitated payment versus a -- either capitated or negotiated payment versus a fee-for-service impact.

DR. MARK MILLER: Would you give me another pass at that?

MS. HANSEN: I'm just thinking about, say you have a nursing home -- but for some reason it just struck me much more with the IRF. You have a nursing home who has maybe 30 percent of its business on negotiated payments with a health plan, as compared to a fee-for-service approach.

Does that have any impact at all, in terms of the cost margins, in general? I know we don't probably have access to that, because that's private information. But it just struck me about what impact does a higher penetration of contracts that are negotiated contracts versus fee-for-service contracts have on any of these lines of business?

DR. MARK MILLER: And also, I would take your question as negotiated contracts that have a capitated fee, as opposed to a per diem or something like that?

MS. HANSEN: It could be either one.

DR. MARK MILLER: Either one.

DR. MARK MILLER: I'm going to take a shot here. We don't know. We take your question -- unless I'm missing something, that you guys have been up to that I'm unaware of.

I do take your question now and let us see what we can find on it.

MR. GEORGE MILLER: Yes, I would ask a similar question I ask most times. Do you have the demographic information on -- at least I didn't read it, I don't know if I missed it -- on those patients that go to IRFs? And also age distribution, as you did last time, as well.

MS. NEUMAN: We do not have that information right now, but it's something we could add for the future.

MR. GEORGE MILLER: Thank you.

DR. CROSSON: Yes, Kim, just on slide number 10 as the numbers, in the first column, the breakdown. The breakdown between non-profit, as you have it, and for

profit, sums to 85 percent. Is there a third category there, government hospitals? What's the third category?

MS. NEUMAN: It's government and other kind of ownership structures.

DR. CROSSON: Thank you.

DR. KANE: What proportion of the IRF is Medicare?

MS. NEUMAN: It's about 60 percent Medicare fee-for-service.

DR. KANE: Do we know, is the rest mostly Medicaid or is it private pay? It's about 60 percent.

MR. LISK: It's a combination of private pay and Medicaid.

DR. KANE: We don't have a sense, though? Unlike skilled nursing, it's not as high --

MR. LISK: Medicare is the largest payer in this sector.

DR. KANE: And what have been the actual updates for the last three to five years for IRFs?

MS. NEUMAN: The Congress froze the payment rates for IRFs for the last half of 2008 and all of 2009 at the 2007 levels. So they fell back to the 2007 levels for that year-and-a-half period.

There was a full update in 2010.

DR. KANE: Do we know why they froze the rates?

MR. HACKBARTH: It had to do with the deal around the transition to the 75 percent rule. And they froze them at 60-what percent; right? They didn't have to go all of the way to the 75 percent rule.

MS. NEUMAN: There were kind of two freezes going on. There was the compliance threshold idea, where they were phasing the compliance threshold up to 75 percent and Congress decided to set it at 60 and leave it there permanently because of, you know, concerns about what is the right number.

Then there was also the issue of the update to the standardized amount. That was frozen or set back to the 2007 levels for that year-and-a-half period, I think because of concerns about the higher margins that have been in the sector.

MR. HACKBARTH: Yes, and so Congress felt that they were giving them something on the 75 percent rule and exacted something on the rate side as compensation.

DR. CASTELLANOS: With the increase in the severity of the patients and the case-mix, where do we stand

with quality? What are we looking at?

I'll be very honest, the reason I'm asking this question is I have a colleague that goes around the country and looks at these. I just had a conversation with him. He said there's a tremendous variation in quality in the units.

I'm just wondering, we don't seem to be addressing that.

MS. NEUMAN: Quality is an area that we want to get into in more depth. We have contracted with RTI to do a study to try to look at risk-adjusted quality measurement in the IRF sector. So one of the things we would be looking at is the risk-adjusted change in functional status between admission and discharge.

In addition, as a part of that study, we're also looking at potentially other things like discharge to the community, because that's one of the key functions of IRFs is to get people back home. And then also seeing what we can do in the area of readmissions.

So that's all underway and still in development. I can't tell you how it will end up but we are trying to make headway in that area.

MR. HACKBARTH: Other round one -- Mitra?

MS. BEHROOZI: Yes, just on the payer mix. You're very precise about saying that 60 percent of the payer mix is fee-for-service Medicare. Do we know anything about the Medicare Advantage side? Do Medicare Advantage plans use IRFs? Do we know to what extent?

MS. NEUMAN: They do use IRFs and we've had some access to some proprietary data which suggests that there has been sort of an increase in the use of IRFs among the managed care population. Now, we know the managed care population has grown, so to the extent to which that's population growth versus use growth, it's hard to know.

But it does seem to be used within the Medicare Advantage population.

MR. LISK: And just to say, in terms of the total for the Medicare Advantage, it's kind of a little bit of an unknown. But actual total IRF volume actually increased for the first time between 2007 and 2008, since the 60 percent rule has been in effect. So for total -- so actually, that slight decline in the Medicare fee-for-service, it actually was an increase overall.

MR. HACKBARTH: okay, round two comments?

MR. BUTLER: Okay, left to myself, I'd vote for --

on the hospital side -- a market basket minus productivity. But in the spirit of compromise, I won't. But I did want to make a point, nevertheless.

This is an area that's undergone a lot of change and appropriately, through the 75 percent rule and other things, got the joint replacements out of these places and into a more appropriate setting.

There's also certain kinds of cases that are rehabbed, say a traumatic brain injury, that a long stay can clearly be better done in a free-standing place.

I think there are some specific chronic diseases or acute episodes, I should say, that can be uniquely done by hospital-based SNF, like stroke, that are far superior than sending them to, for example, a free-standing unit or a nursing home.

And I think this is part of -- I think we need to understand a little bit better the kinds of complex patients that could be best treated in a hospital-based unit over time so we understand these difference a little bit better. I think we've made good progress in this area overall of sorting these out. But if we can really get down to that, I think that would be a great addition in the future.

That's how we look at it, at least in our own institution.

MR. HACKBARTH: Would you put up the draft recommendation? Thank you.

All in favor of the recommendation, please raise your hand? Opposed? Abstentions? Thank you.

And next is long-term care hospitals.

MS. KELLEY: Okay. So first, I'm just going to give a quick sketch of the long-term care hospital industry. You'll recall that LTCHs furnish care to patients with clinically complex problems who need hospital-level care for relatively extended periods.

In 2008, about 115,000 beneficiaries had about 130,900 LTCH stays and Medicare spent $4.6 billion on this care. Three-hundred-and-seventy-nine LTCHs filed Medicare cost reports in 2008. Medicare's payments to LTCHs are made on a per discharge basis based on the MS-LTC-DRGs, and these are the same groups that are used in the acute inpatient PPS, but with relative weights that are specific to LTCH cases.

Now, I'll just go through and summarize the results of our analysis of beneficiaries' access to care,

the quality of care, providers' access to capital, and Medicare's payments and providers' costs for these services.

First, to assess beneficiary access, we looked at capacity and supply. As you can see here in green, the supply of LTCH facilities has stabilized after a period of rapid growth, and growth in the number of LTCH beds, shown here in red, has also remained fairly steady.

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 remain positive while length of stay declined very slightly between 2007 and 2008.

Last month, we discussed the Commission's previous use of four AHRQ patient safety indicators to measure adverse events across all LTCHs and our decision not to use PSIs this year for LTCHs in light of a recent AHRQ report about the validity of those four PSIs. So as we promised last month, we did examine trends in in-facility mortality, mortality within three days of discharge, and readmission to acute care to address aggregate unadjusted changes in quality of care in LTCHs. We examined trends in these

measures rather than levels because levels can reflect both planned readmissions and unplanned incidents, as well as coding practices.

We looked at these measures for the top 15 LTCH diagnoses and for all diagnoses combined. We found that readmission rates have been stable or declining for most of the top 15 diagnoses. Trends in rates of death in the LTCH and death within 30 days of discharge are more difficult to interpret on a diagnosis basis, but over all diagnoses, both death rates remain stable, as did readmission rates over all diagnoses.

As we also discussed last month, we're very concerned about the lack of reliable quality measures for LTCHs, and our plan going forward is to explore the development of these measures beginning with an expert panel to help us identify meaningful measures in the data that would be needed for measurement, and we also plan to work with a contractor to assess the feasibility of risk-adjusted quality measurement at the provider level. So that's something we hope to report to you on in the coming cycle.

Last year, the economy-wide credit crisis meant that LTCHs' difficulty access capital at that time told us

little about Medicare payment adequacy. One year later, as you've heard previously today, credit markets are operating in a more normal manner, but the three-year moratorium on new LTCH beds and facilities imposed by MMSEA has reduced both the opportunities for expansion and the need for capital, though, of course, not eliminated totally those opportunities or needs.

Overall, the 2008 margin was 3.4 percent. You can see here that margins vary across different types of LTCHs. Rural LTCHs and nonprofit LTCHs have significantly lower margins, on average, than urban and for-profit LTCHs. Rural facilities are very small in number. There are about 30 or so rural LTCHs, and as you can see, they care for about four percent of all LTCH cases. They also care for a lower volume of patients in their facilities, as do nonprofit LTCHs compared with the urban and for-profit counterparts. So that may result in poorer economies of scale for those facilities.

We looked more closely at high- and low-margin LTCHs to get a better idea of what's driving the margins. This slide compares LTCHs in the top quartile of margins with those in the bottom quartile. There's a lot going on

here, so let me walk you through it.

The first two columns show average standardized cost per discharge and the average Medicare payment per discharge. You can see that the big difference underlying the financial performance of these LTCHs is per discharge cost, not higher payments. In the third row, you can see that high-margin LTCHs care for a higher volume of patients, on average, than do low-margin LTCHs, 372 discharges annually versus 242. As with urban facilities, this higher volume in high-margin facilities may allow for better economies of scale.

The Commission has hypothesized in previous reports that because the medically complex patients requiring lengthy hospital stays are relatively rare, that a critical mass of these medically complex patients might be necessary to ensure that providers have adequate experience in caring for these patients. The comparison of high- and low-margin LTCHs suggests that a critical mass of patients might also be needed to achieve economies of scale. This is something we are going to look at more in the future, but if this holds true, it might be most appropriate to view LTCHs and other providers of medically complex care as referral

centers serving wider catchment areas. Such referral centers might be able to provide more value for the Medicare program by achieving better outcomes with greater efficiency. Obviously, the development of quality measures will be necessary to evaluate whether this care model would work.

Returning to the slide for just a minute, as you can see in the fourth row, high-margin LTCHs had shorter average lengths of stay while maintaining the required length of stay of greater than 25 days. The next two lines show high cost outlier payments per discharge and the share of short-stay outlier cases. You can see that low-margin LTCHs had high cost outlier payments that were more than twice those of high-margin LTCHs. At the same time, a larger share of low-margin LTCHs cases are short-stay outliers, 35 percent versus 28 percent. So low-margin LTCHs care for a disproportionate share of patients who are high cost outliers and a disproportionate share of patients who are short-stay outliers. Both types of patients can have a negative effect on LTCHs' margins. LTCHs lose money on high-cost outlier cases since by definition they generate costs in excess of their payments. And LTCHs also typically

receive reduced payments for their short-stay outlier cases.

And finally, in the last row, you can see that high-margin LTCHs are much more likely to be for-profit facilities than low-margin LTCHs.

Our projected margin for 2010 is 5.8 percent. In the absence of behavior changes, we do expect that payments will grow more quickly than costs in 2009 and 2010. This is due to Congressional rollbacks of CMS regulations that were designed to reduce payments to LTCHs. With these regulations on hold under MMSEA, se expect payments to rise. In addition, we anticipate improvements in documentation and coding will increase payments, particularly in 2009, and changes to high cost outlier payments in 2010 will also boost aggregate payments.

So moving on to the draft recommendation that you discussed last month, it reads as follows. "The Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2011."

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2011 will produce savings relative to the market basket. We don't anticipate any

adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

So that concludes my presentation and I am happy to answer any questions.

MR. HACKBARTH: Thank you, Dana.

Let's start on this side over here, round one clarifying questions. Nancy?

DR. KANE: Yes, on page nine, when you're talking about average yearly discharges, is that all patients or just Medicare discharges?

MS. KELLEY: Medicare only.

DR. KANE: So they could have comparable lines f you looked at all patients?

MS. KELLEY: Medicare counts for about 70 percent of LTCH patients in aggregate.

DR. KANE: But you'd have to look at -- I mean, you'd have to --

MS. KELLEY: Yes.

DR. KANE: It would be useful to see whether that is the case --

MS. KELLEY: Okay.

DR. KANE: -- that they're just low volume

overall, because that would help spread the costs.

And you said -- and what proportion of hospitals have LTCHs?

MS. KELLEY: I don't know offhand.

DR. MARK MILLER: So I thought you had a problem with the hospital within --

MS. KELLEY: Yes. We talked about this last time. Thank you, Mark. We talked about this last time, about our difficulty determining what are hospital within hospital facilities and what are LTCHs -- what are freestanding facilities. So this is something that I have been working on with the help of Jae Yang, and we're trying to get some better clarification of that and that will allow us to make a more accurate estimate of how many hospitals have LTCHs, and it will also -- we hope going forward to be able to look at how having an LTCH affects an acute care hospital margin, so --

DR. KANE: Yes. So just generally for all these post-acute providers, it would be really nice to have the group that does hospital stays --

MS. KELLEY: Yes.

DR. KANE: -- taken out and looked at so that we -

- just so we can get a sense of what's going on, even though we want to look at the margins combined at some point. But it's nice to see them broken out. It really helps think about what it means.

DR. CROSSON: Yes. Dana, also on Slide 9, as I look at the difference in the standardized cost, which is 50 percent, about, higher in the low-margin LTCHs, try to think about what might be causing that. It's hard for me to believe that the difference in volume between 372 and 242 is -- I mean, that's different, but it's not different by an order of magnitude or anything close to that. It's hard to believe that that's the cause of it, and that the high cost outliers is more a consequence, isn't it, of the cost phenomenon than the cause, right? So I can't -- and the short-stay outlier difference is not so great, either, just intuitively to suggest that that's the cause. So it seems to me that perhaps we, if we're going to look at this, we need some more information about what that difference might be due to.

MS. KELLEY: Absolutely, and one thing we're looking at more closely is just the different types of cases that might be in these different facilities and also within

DRGs, severity levels, and that will be something that will, I hope, will help us tease out a little bit more of this.

I think there's a lot going on here. I think that some preliminary numbers that I've looked at suggest that, to the extent that we can trust our hospital within a hospital, that low-margin LTCHs are more likely to be in hospitals within hospitals or associated with a hospital and we do -- I do see a difference in the shares of patients from different DRGs. So one thing that will be -- RTI did do some work previously suggesting that there's quite a difference in profitability across different types of cases, so these are all things that I hope we can tease out.

DR. CROSSON: Just one follow-up, then. So the idea that if you have a long-term care hospital within another hospital versus free-standing, it's then carrying greater overhead, is that the difference, or don't know?

MS. KELLEY: I don't think we would know. You know, it may be a case similar to what I think Carol was talking about in SNFs, where you see that margins in the LTCH might not be very high, but they might be reflected in higher margins on the acute inpatient side. So, you know, this is all something we're hoping to get a better handle

on.

DR. MARK MILLER: In this area, I know, Nancy, you know, what you keep saying that we need to understand. Here, I think even the marriage between these two is even murkier. Even when you're a hospital within a hospital -- if I say something wrong, somebody is going to say something right. I know Glenn will.

A hospital within a hospital, you are supposed to be financially separate from the facility. So here, it's even yet a different animal than some of the ones, because even though it might be on the campus, and as I understand it, they don't even have to necessarily be on the campus, or they can be some distance from one another. So the complexity here is I'm a hospital within hospital. By the way, I'm not located in the hospital. So that's the first problem. Not to mention that we can't count these things very well.

And then, number two, even though I'm a hospital within a hospital and we've been talking about these relationships, financially, they are supposed to be separate entities. But then they could have this effect in their presence, being present in the hospital, on the inpatient

side.

The other thing I'm just going to throw in for good measure here is this animal also may be different in the sense that, you know, there's a sense that the patient who shows up here is a unique patient or relative -- do you want to jump in?

MR. HACKBARTH: Well, that was going to be -- I was going to mention is that one of our issues about LTCHs is whether the patients -- which patients are going into these institutions that the appropriate patients are not, and absent a real clear patient criteria, it could be that these institutions are used for very different types of patients depending on the local health care setting and alternatives, and so that may account for the extraordinary heterogeneity in cost per case even after adjusting for case mix.

MS. KELLEY: Right, and I think that the difference in high cost outliers in the low-margin facilities and those short-stay outlier cases, as well, although the short-stay outlier difference is not enormous, I do think that suggests that there's a different kind of selection perhaps going on in different kinds of facilities.

DR. MARK MILLER: The last thing I will say, and I'm sorry, but there's also this notion of kind of the volume and bed size where we do see -- we're going to look at these relationships. A conversation we've been having internally is whether you want to think of these things more as a referral center type of concept, where it's like you need a critical mass to deal with these types of patients well, and one policy idea we want to start talking through is do you want to sort of almost have a Centers of Excellence concept to these types of operations and sort of -- again, trying to get behind some of the economy of scale. And if the quality tracks the scale, then that would be kind of one direction we'd be back here talking to you about.

MS. KELLEY: Yes. I guess the last thing I would say is just to underline your point, Mark, about the totally separate financial entities. They file their own cost reports. They're supposed to have their own boards. And so it's much more difficult to match these up with hospitals. And I think when we first started thinking about the hospital within hospital concept, we were thinking about a wing of a hospital or a floor. It becomes more and more difficult to kind of -- as an LTCH springs up across the

street from the hospital, is that a hospital within hospital or is it a freestanding facility, and what about if it's down -- you know, it just becomes more and more difficult to figure out what the entities are and what the relationship with the acute care hospital is.

DR. KANE: Aren't they constrained by how many admissions they can take from their hospital host? So don't they have to define who that is --

MS. KELLEY: Yes.

DR. KANE: -- or has that just gone by the wayside?

MS. KELLEY: Yes, they do, and we're not convinced that CMS does a very good job with that.

MR. BERTKO: Okay. A similar kind of question. These hospitals are only in about ten percent of the counties in the U.S., so when you don't have one, who treats the patient and how is it done? And then to Mark's concept, or Glenn's, about referral, are there any examples where there are already referral centers, or do people just get treated by a totally different group of providers?

MS. KELLEY: To your first question, that's right, that these are located in very specific areas of the

country. Where there aren't LTCHs, we think that it appears that similar patients that are cared in LTCHs stay in the hospital longer. They have longer acute-care hospital lengths of stay. And then to some extent, they use SNFs a little bit longer. But I suspect -- it looks as if most of the care is taking place in the acute-care hospital.

The referral center idea is -- I think that's something we could try and take a look at by identifying communities, sort of matching communities in which there's one LTCH versus one with many and be able to look at perhaps the distribution of patients and costs.

MR. BERTKO: So I guess the follow-up for this year would be it would be interesting to look at the cost in those non-LTCH areas where you might be paying some outlier payment for the hospital stay plus some SNF stay --

MS. KELLEY: Well, that is something that MedPAC did several years ago, I believe, using 2001 data, and what we've -- what?

MR. BERTKO: And the answer is?

MS. KELLEY: The answer was that for the most severely ill patients, for example, when we looked at ventilator patients, you know, difficult-to-wean ventilator

patients, the cost between -- the costs in LTCHs versus patients who didn't use LTCHs were actually rather similar.

MR. BERTKO: Okay.

MS. KELLEY: What we, of course, didn't really know was how outcomes and quality compared. But when we looked at other patients, as severity fell off, the value of using an LTCH -- the LTCH became much more costly --

MR. BERTKO: Yes.

MS. KELLEY: -- than acute care hospital care.

MR. HACKBARTH: And that analysis was the origin of our recommendation that there be a patient and facility criteria.

MS. KELLEY: Right. Right.

MR. HACKBARTH: Actually, Karen was going to ask the same question as John. George and then Herb.

MR. GEORGE MILLER: John asked my question, so like the last presentation, do you have maps that you could show where LTCHs are across the United States?

MS. KELLEY: I don't have it in my presentation today, but I do have that --

MR. GEORGE MILLER: Yes --

MS. KELLEY: -- and we did publish a map in our

report last year.

MR. GEORGE MILLER: Yes, but --

MS. KELLEY: We can do that this year, as well, and that shows clearly the areas that have them.

MR. HACKBARTH: That isn't in the chapter --

MR. GEORGE MILLER: No.

MR. HACKBARTH: -- this year's chapter?

MS. KELLEY: It's not in this year's chapter --

MR. GEORGE MILLER: No.

MS. KELLEY: -- but it can be, yes, certainly.

MR. GEORGE MILLER: It would just be helpful, because, again, John hit my question, where do patients go, so I won't repeat that. But do you also have the demographic information and age --

MS. KELLEY: I'm sorry, George. I don't have it with me today, but I do have that information and I will add it to the chapter.

MR. GEORGE MILLER: Okay. Great. Great. Great. I'll wait until round two. Thank you.

MS. KELLEY: Okay.

MR. KUHN: Dana, just two quick things. One, thank you for the chart here on page nine that's up here. I

thought this was really helpful information. And I appreciate hearing the fact that you're going to look at conditions, whether it's wound care, vents, different things like that. I think that will be very helpful to us.

I guess the question, and Glenn talked about this earlier, the assessment instrument, the criteria instrument. CMS is charged to develop one, and where are they in that process and when is the due date for that particular product?

MS. KELLEY: I think you are referring to the report on criteria for LTCHs?

MR. KUHN: Yes, right.

MS. KELLEY: That report was due last June and my understanding is that it's in the final stages of clearance.

MR. KUHN: Thank you.

MR. HACKBARTH: Herb, I thought you were supposed to finish that report.

[Laughter.]

MR. KUHN: Are you going to give me a pass on that one?

MR. HACKBARTH: Other clarifying questions?

Round two comments? Peter?

MR. BUTLER: So I find the referral concept as a very good one. I think the clear population in my mind that -- and maybe it's a lot narrower than that being currently treated -- is the difficult-to-wean ventilator patients, that I think these institutions can do better in.

I would suggest that I can support the recommendation, but I also would suggest that perhaps we should look at the few big systems that have -- they are both integrated systems that have large capitated lives. So if you take a Henry Ford or if you take Intermountain or Presbyterian Albuquerque, it would be interesting to look at where you have a critical mass of population, how they are managing those high-end ventilator patients, whether they are leaving them in the ICUs and not -- but they have enough to do that, and I wonder if they're doing --

MR. HACKBARTH: Kaiser.

MR. BUTLER: Well, Kaiser a little bit in one of your concentrated markets, maybe, and it could apply, for that matter, to all these post-acute things. We might learn a little bit more about the decisions that have been made voluntarily when you are driven -- you are at the tipping point and the capitation dollars are driving the decisions,

not the Medicare payment system.

MR. HACKBARTH: That intrigues me, as well. I think that might be interesting research.

Other round two comments? Tom?

DR. DEAN: I had the same thought that Peter did. Just to reemphasize that, we've got a concept here that it would appear is not a totally proven concept, and I think it'd be really important to try to look at how this is handled in other settings and try to figure out which, both in terms of outcome measurements as well as cost measurements, what works the best, because it seems to me we clearly don't know at this point.

MR. HACKBARTH: Okay. I think we're ready to vote. Please put up the recommendation. All in favor, raise your hand. Opposed? Abstentions?

Thank you, Dana. And on we go to hospice.

MS. NEUMAN: Good afternoon. We are now going to going to take a look at payment adequacy for hospice services. This seems to be stuck.

MR. HACKBARTH: Mark and I had a bet whether we could finish on time, and I said we were going to finish on time, and he has intentionally sabotaged it.

DR. MARK MILLER: Throw the ball out of bounds.

[Laughter.]

MS. NEUMAN: So go ahead?

MR. HACKBARTH: Yes, and I apologize to folks in the audience. We'll get it up and going as quickly as we can.

MS. NEUMAN: For a brief overview of hospice, hospice provides palliative and supportive services to terminally ill beneficiaries who choose to enroll. In 2008, more than 1 million Medicare beneficiaries received hospice service from over 3,300 hospices, with Medicare spending exceeding $11 billion.

As we discussed in December, our indicators of payment adequacy are generally positive. In terms of the supply of hospices, the number of hospices increased substantially in the last decade, growing from about 2,300 providers in 2001 to more than 3,300 providers in 2008. The increase in the number hospices has been driven largely by growth in for-profit, freestanding providers.

Hospice use among Medicare decedents has also grown substantially. From 2000 to 2008, the percent of Medicare decedents using hospice grew from 23 percent to 40

percent. Over this time period, hospice use increased across all demographic characteristics we examined -- gender, age, race/ethnicity -- although there continues to be a lower prevalence of hospice use among racial and ethnic minorities.

Between 2000 and 2008, Medicare hospice spending almost quadrupled, as the number of hospice users and average length of stay increased. During this time period, the number of hospice users doubled from just over 500,000 to just over a million, and average length of stay increased from 54 days to 83 days.

As you'll recall, the increase in length of stay reflects largely an increase in very long hospice stays. At the 90th percentile, hospice length of stay increased from 141 days to 235 days between 2000 and 2008. The increase in long hospice stays is partly the result of the enrollment of more beneficiaries with non-cancer diagnoses for whom it may be harder to predict life expectancy. But that does not explain all of the increase. Some providers -- particularly providers that exceed Medicare's aggregate cap on hospice payments -- have more long-stay patients across all diagnoses.

We estimate that the share of hospices exceeding the cap in 2007 was about 10 percent. Above-cap hospices are almost entirely for-profit. They have very long lengths of stay and unusually high rates of discharging patients alive. This may suggest that above-cap hospices are enrolling beneficiaries before they are ready for the Medicare hospice benefit.

In our discussion at the December meeting, a couple Commissioners had questions about above-cap hospices. Glenn, you asked about the high discharged-alive rates. Included in the mailing materials are data on the rates of live discharges by patient diagnosis for above- and below-cap hospices, which showed that above-cap hospices have very high live discharge rates, even after controlling for diagnosis.

John, you asked if CMS was doing any additional scrutiny of above-cap hospices. In talking with CMS staff, they indicated that the claims processing contractors have a number of medical review activities currently underway in this area, with efforts to look at both patients with long stays in general and patients in cap hospices.

Finally, one last point on the hospice cap. As we

discussed in detail at the December meeting and in your mailing materials, we have looked at the relationship between hospice use rates and the share of hospices hitting the cap by state and have found no evidence that the hospice cap impedes access to care overall or for racial and ethnic minorities.

Now moving on to hospice quality, we are currently unable to assess hospice quality of care, as there are no publicly available data on hospice quality that cover all hospices. Some hospice industry associations have surveys of family members and patients, but the data are not public and do not cover all hospices. A hospice foundation is developing a public report card that will use some of this survey data, but participation will be voluntary. And CMS is currently testing 12 hospice quality measures in seven hospices in New York.

Now looking at access to capital, with regard to hospice, it is important to keep in mind that hospice is less capital intensive than some other provider types. Overall, access to capital appears to be adequate for large publicly traded hospice companies, for-profit freestanding hospices, and for hospital-based and home health-based

hospices. Access to capital for nonprofit freestanding providers is more difficult to discern, but, Nancy, we are exploring your idea about using data from the 990 data to try to look at that.

The next slide shows our estimates of aggregate Medicare margins for hospice over time. From 2001 to 2007, the aggregate hospice Medicare margin oscillated between roughly 4.5 percent and 6.5 percent. In 2007, the aggregate margin was 5.9 percent, down slightly from 6.4 percent in 2006.

A couple points to remember about how we've estimated margins:

First, we do not count Medicare overpayments to cap hospices in our estimate of hospice revenues since cap hospices must ultimately pay these payments back to the government.

Second, consistent with our methodology in other Medicare sectors, we calculate margins based on Medicare reimbursable costs.

As we discussed at the December meeting, bereavement costs are considered nonreimbursable and are consequently not included in our margin estimates. The

statute requires that hospices offer bereavement services to the family members of their deceased Medicare patients, but the statute also specifies that bereavement services are not reimbursable. If bereavement costs were included in our margin estimates, it would reduce the aggregate margin by about 1.5 percentage points.

The next slide shows hospice margins by type of provider. In 2007, freestanding hospices had a margin of 8.8 percent compared with 2.3 percent for home health-based hospices and minus 10 percent for hospital-based hospices. Part of the reason for these margin differences is the higher indirect costs among provider-based hospices, which are likely inflated due to the allocation of overhead from the parent provider. If home health-based and hospital-based hospices had indirect cost structures similar to freestanding hospices, we estimate it would increase their margins by 6 to 10 percentage points. And it would increase the overall industry-wide Medicare margin by 2 percentage points.

In terms of margins by type of ownership, for-profit hospices had margins of 10.5 percent compared to non-profit with 1.8 percent. If we look at nonprofit

freestanding hospices, which would not be affected by overhead allocation issues, nonprofit margins are higher -- 5.6 percent.

Our projected aggregate Medicare margin for hospice in 2010 is 4.6 percent. This projection takes into account the effect of the seven-year phase-out of the wage index budget neutrality adjustment, which will reduce Medicare payments to hospices by about one percentage point in 2011.

With that I'll read the draft recommendation: "The Congress should update the payment rates for hospice for fiscal year 2011 by the projected rate of increase in the hospital market basket index less the Commission's adjustment for productivity growth." Based on the current market basket projection, this draft recommendation would result in an update of 1.1 percent for 2011.

In terms of the impact, the draft recommendation would decrease federal spending by between $50 million and $250 million over one year and between $1 billion and $5 billion over five years. We anticipate no adverse impact on beneficiaries. There may be increased financial pressure on some providers, but overall we expect a minimal effect on

providers' willingness and ability to care for Medicare beneficiaries.

As you know, the draft update recommendation would affect aggregate payment levels. The Commission also made recommendations in March 2009 to reform the hospice payment system that would affect the distribution of payments. The payment system reform recommended by the Commission would have the effect of increasing payments for hospices that tend to have fewer very-long-stay patients, which would increase payments to rural hospices and nonprofit hospices.

We plan to reprint the March 2009 recommendations in the 2010 report, and to review them briefly:

First, there was the payment system reform recommendation which would change the payment stream from a flat stream to a U-shaped stream that more closely matches hospices on level of effort throughout the episode of care.

Then there were also recommendations concerning increasing accountability, so this included steps like requiring that a physician narrative be included in all hospice certifications and recertifications, and CMS has adopted this piece of the recommendation. It also included requiring that a physician or APN visit a long-stay patient

prior to recertifying their eligibility, and also increased medical review of claims for hospices with many long-stay patients, and, additionally, OIG studies of nursing home and hospice relationships. The final piece of the recommendation was additional data reporting in the areas of the claims and the cost reports to facilitate payment system reform as well as better oversight of the benefit.

With that, I'll conclude the presentation and look forward to your discussion.

MR. HACKBARTH: Nice job, Kim.

Clarifying questions?

DR. DEAN: On Slide 6, that rise in cost is pretty dramatic. Are those constant dollars? Is that inflation adjusted or --

MS. NEUMAN: Those are not inflation adjusted.

DR. DEAN: Okay, so some of it would be inflation, but I suppose -- is the biggest issue to account for that jump in cost is just the change in length of stay? Would that be the biggest issue? Or do you know?

MS. NEUMAN: It's really a combination of the number of users -- you can see the number of users has gone up substantially.

DR. DEAN: The number of users has doubled and the cost quadrupled.

MS. NEUMAN: Right. So you've got the number of users doubling. You've got the average length of stay going up by -- what? -- roughly 50 percent as well. And then you have the payment updates, and the payment updates, you know, it's the hospital market basket. So we are talking, you know, 2, 3 percent a year, that would be impacting it as well.

MS. HANSEN: Kim, relative to the ones that exceed the cap and people get discharged back out from the hospice program, is there any description as to where they go?

MS. NEUMAN: It's a hard question to answer in a couple of respects. What I can tell you is that we can look and see how long folks lives after they've been discharged from hospice, and, you know, we see that especially for the above-cap hospices, more than half are alive a year after they're discharged. So we can look at things like that. We can also look at re-enrollment. Some of these people do wind up re-enrolling back into hospice.

As far as looking at if they then go on to receive lots of physician services or what kind of services that

they receive from the Medicare program once they're out of hospice, I haven't looked at that, but that's something that we could look at.

MS. HANSEN: Okay, great. Thank you. And then just another question relative to the profiles of the hospice programs themselves. Are we able to look at how many of them serve both dual payers like Medicare and Medicaid as well?

MS. NEUMAN: I think we should be able to. I haven't looked at that, but I can check into that.

MS. HANSEN: Thank you.

MR. GEORGE MILLER: I have a similar question to Jennie concerning those folks who live longer than expected, and I don't know what that has to do with your recommendation about having the OIG look at it, but I'm wondering -- I'm not picking on physicians, but just wondering if the physician has to certify that a hospice patient probably -- the growth in those folks living longer seems to be contraindicated to a physician's guesstimate they only have six months to live. But is there a reason you tied that to OIG inspection of hospice programs, or am I way off base?

MS. NEUMAN: We would expect some benefits to --

MR. GEORGE MILLER: Some.

MS. NEUMAN: -- live beyond sort of the 180-day presumptive kind of eligibility period because diseases don't always run their normal course.

MR. GEORGE MILLER: Right.

MS. NEUMAN: So that is completely to be expected, and there's nothing necessarily inappropriate -- well, there is nothing inappropriate about that, obviously.

MR. GEORGE MILLER: Right.

MS. NEUMAN: The question really becomes when we start to see patterns that are very different from what we see among the majority of the industry, that's where you start to wonder whether the benefit is being used appropriately in certain cases, and so the Commission recommended in March 2009 to have the OIG look at a number of issues, including aberrant utilization patterns. So for hospices that have very unusual utilization patterns, to look at those kinds of things and see if there are some issues going on there.

In the chapter, we have a discussion about how perhaps that should include looking at hospices that have

very high rates of patients being discharged alive.

MR. GEORGE MILLER: Right.

MS. NEUMAN: To similarly get someone to take a look at that issue.

MR. GEORGE MILLER: Thank you.

DR. MARK MILLER: We also at that time made some recommendations to try and put, you know, greater accountability on the physician having to have a visit in order to certify the patient, so it wasn't just the IG looking at the patterns. There were a few other things that were trying to get at that as well.

MR. GEORGE MILLER: There's a correlation between the increase in length of stay and the increase in payments.

DR. MARK MILLER: And an increase in what?

MR. GEORGE MILLER: In payments to the program.

MR. HACKBARTH: And increase profitability as well.

MR. GEORGE MILLER: Absolutely, yeah.

MR. HACKBARTH: Let me just make what has become a standard comment for people in the audience who have not been at prior MedPAC discussions of hospice. We are focused on the growing length of stay and, in particular, as Kim

says, hospices that seem to have a real pattern of extra long stays.

The issue is the timing of the entry into hospice. Nobody is looking for earlier deaths for people. It's really the timing of the admission to hospice that's the issue.

MS. BEHROOZI: Forgive me if this has been asked and answered a million times in prior presentations and, you know, prior years even. But why is it the hospital market basket that we're using to judge the inflation in the input side?

MS. NEUMAN: I don't know if I know the history of why the hospital market basket was chosen.

MS. BEHROOZI: I don't know how important the history is. Really, the follow-up question is: Do we think that is a problem the same way in ASCs, you know, we thought we should relook at it? But I don't know if there has been thinking about whether it's appropriate or a problem to use. That's more my question.

DR. MARK MILLER: I think the answer is -- and I probably will garble this -- we did some work a couple years ago on reforming the wage index for hospitals. That was our

primary focus. But at the time, given the way we recommended to change it, we also said that given the -- you could fairly easily within that context shift the relative weights of mixes and use a comparable index across these -- I'm not describing this right, David?

MR. HACKBARTH: Would you come to a microphone, David?

MR. GLASS: That analysis actually affected the relatives between two areas, and those stayed about the same despite the mix of occupations. But we didn't look at the levels.

DR. MARK MILLER: Right. You're right. I'm sorry.

That was just a delay.

MR. HACKBARTH: Another one. A good point. We'll think about that issue.

Other round one comments?

DR. BERENSON: And again, like Mitra, if this was asked in December, I apologize. But why is it that Congress excluded payment for bereavement and I guess the mandatory volunteerism programs? Is it because these are services provided to non-Medicare benefits or some other reason?

MS. NEUMAN: On the bereavement, from what we understand from talking to folks who were involved in sort of the development of all this back in the early 1980s, there was concern about making a payment for services once the beneficiary for whom the benefit is really being -- you know, sort of the entitlement for the benefit attaches to has been deceased. So that was the reason for nonpayment for bereavement. And, in general, the volunteer services are not paid for under the Medicare program.

DR. BERENSON: And the follow-up question: Have we -- I mean, how far back has MedPAC's policy gone that -- I guess my specific question is: The hospice margins that you're citing going back a number of years have used the same definition of excluding bereavement and volunteerism programs?

MS. NEUMAN: The hospice margins that we have published previously included those costs. What we did in preparing for putting this in the update framework for the first time this year was to go back and take a look at our methodology to examine how it compared to our methodology in the other sectors and to make it as consistent as possible to that, and that's why these margins now are based on only

Medicare reimbursable costs.

MR. HACKBARTH: And that's true for the whole time series, all the different years in this series.

MS. NEUMAN: Yes. Everything you see on the screen --

DR. BERENSON: So it is true for the whole time series that you're using.

MS. NEUMAN: Yes.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: Round two comments on the recommendation?

DR. BERENSON: I support the recommendation, and I just wanted to make an observation that I'm as impressed by the data you haven't emphasized, which is that the median length of stay hasn't changed in eight years. It's still 17 days. And, in fact, at the 25th quintile, it has gone down from six to five. So our focus, which I think is fine, on these outliers in trying to address it I think masks the issue that we still have a problem of too late referrals and that in our work going forward we want to not miss that. And I don't have a glib solution today, but I think we

should be dealing with both ends, that the means sort of masks what's going on with the majority of patients.

DR. KANE: I guess I would like to be convinced that the hospice with a projected margin of 4-point-whatever -- I can't read this very well -- 4.8 or 4.9 -- 4.6 deserves an update, whereas the LTCHs and the IRFs with margins in the 5- to 6-percent projected don't deserve an update, and the supply characteristics and everything else, you know, I mean, people seem to be very happy to offer hospice, maybe more hospice than we want them to offer for the wrong patients, there's a mismatch, but not early enough for the right ones. But, anyway, I guess I'm a little confused as to why we have market basket minus productivity, and is there some historic -- you know, what the actual updates have been piece? And if that's going to be in our recommendations what the historic actual was, we should have it in here as a consideration every time? So I guess I'm a little -- I don't feel convinced that they should have -- that they are any more deserving of an update than the other post-acutes.

MR. HACKBARTH: Good question. As in previous cases, you know, there is no right answer to these, although

trying to achieve some consistency is important.

DR. KANE: I'm trying to be consistent.

MR. HACKBARTH: The second comment is the 4.6 here, as I recall, includes the bereavement costs, and as I said in December, part of my thinking about this -- or, excuse me, without the bereavement costs. Kim was giving me that look. The 4.6 does not include the bereavement costs, and as I said in December, I'm troubled. I understand the rationale for it, that these are services to non-Medicare beneficiaries, but they are required services. And so in my own personal calculation and trying to think about what an appropriate recommendation was, I took them into account. So if you reduce the 4.6 by 1.5, you know, you're down to 3.1. So that was one consideration.

The second factor in my mind is looking at the history, and not the history of what actual updates they got so much as what the margins, historical margins have been. If you look at the LTCHs and the IRFs, although their margins have come down to within a reasonable distance now of the hospice, the history going back a number of years has been much higher margins, often double-digit margins. And so in my mind, that was also a factor in formulating our

recommendations.

DR. KANE: Well, I mean, I guess -- I mean, I understand the bereavement piece. I'm not sure that historic margins helps. So your assumption in the others, when there is a zero update, is that because they had these double-digit margins, they should have nothing going on -- I mean, I'm --

MR. HACKBARTH: Well, you know, that's money in the bank. I'd much rather have, you know, 12, 12, 12, and be able to put that in the bank.

DR. KANE: If they put it in the bank, yeah.

MR. HACKBARTH: Or, you know, distribute it to shareholders in the case of for-profit providers. I do think trying to look at equity on these things, some look at the history of the payment and how well people have done is a relevant consideration. Reasonable people can disagree with that.

DR. KANE: And what is -- do we have a sense -- oh, you must know what the actual updates have been the last three to five years.

MR. HACKBARTH: For hospice?

DR. KANE: Hospice.

MS. NEUMAN: Just a second. It is right here. It would be the hospital market basket, which I can tell you was --

DR. KANE: It did not take out productivity in the past.

MS. NEUMAN: No. So we had a 3.3 percent in 2008, 3.6 percent in 2009, and then in 2010, the market basket was 2.1 percent, but because of the start of the phase-out of the wage index budget neutrality adjustment, it was only a 1.4-percent update in 2010.

DR. KANE: So it was -- we're asking to take out productivity, and historically it has been market basket.

MR. HACKBARTH: And since we're on this comparability point, which is an important one and the reason we prepared this side by side for the Commissioners, sort of the other direction is, well, is this high enough? I suspect many of the hospice providers are disappointed that it's not full market basket, which they've gotten in recent years. Another reference point on that side in my mind is dialysis facilities where we're projecting margins of 2.5 percent. Dialysis facilities have a history of margins sort of in that level, maybe a little bit higher,

and it doesn't seem to me that you'd want to give hospice any higher update factor than you would for dialysis at comparable levels of margins. So I've tried to look both directions. Those are my reasons and --

DR. KANE: Although some could argue that because dialysis is capital intensive or, you know, there may be potentials for productivity that aren't there in the hospice side. So I'm -- okay, well, I just wanted to get the reason out there on the table because it's a little bit obscure.

MR. HACKBARTH: Other comments before we vote?

DR. SCANLON: This is sort of on the issue of comparability, and I think Nancy raises a good point. In some ways, we shouldn't be, I think, looking at averages. We should be looking at the distribution. Because if we got to the average because we've got, you know, 10 percent of the organizations with extremely high margins and we're using this one policy instrument, the update, we may be sort of understating the increase that really is appropriate for the people at the low end. And so, you know, I don't know whether the best thing to do is to look at medians, to take out the top 10 percent, to take out the top 20, something like that. But I think one needs more of a sense of the

distribution to really understand comparability well.

MR. HACKBARTH: And in there is a question of if you have a distribution where do you set it on the distribution. And, you know, part of our thinking about that, as you well know, is let's look at a distribution, let's not use averages, let's see if we can define efficient providers, low cost, high quality, and increasingly over time peg to that point on the distribution. And, you know, that's an evolving piece of work. We're further along in that in some sectors than in others.

DR. DEAN: Well, I would just echo what Bill just said. I have been troubled as we've had some discussions about the use of averages because they can hide a lot of things. But the question I really had was do we know what the productivity adjustment might be, or do we have an idea of that? And how is productivity measured in this context?

MR. HACKBARTH: For all of the sectors, the productivity measure we use is the increase -- the ten-year moving average and total factor productivity for the economy as a whole, which is about 1.3 percent.

DR. DEAN: [off microphone] It's nothing specific to --

MR. HACKBARTH: Right. And just to emphasize a point that we touched on here, when we make productivity adjustments, we are not trying to estimate the actual productivity change in any particular sector, whether it's hospice or hospital or any other. The purpose of the productivity adjustment is as a policy expectation that, as we discussed this morning, health care providers ought to feel the same sort of pressure to improve their efficiency as do the people who pay the bills, the taxpayers. And that's the reason for the link to economy-wide productivity. So it's not an empirical estimate of actual productivity change but, rather, a policy adjustment.

Other comments before we vote?

[No response.]

MR. HACKBARTH: Okay. All in favor of the hospice recommendation, please raise your hand. Opposed? Abstentions?

Thank you, Kim.

And last for today is home health.

MR. CHRISTMAN: Good afternoon.

I am going to walk you through the framework. Also, I would note that there are a few items that we're

going to follow-up on specific interests of the Commissioners. I'll not those as I come to them.

Quickly, just a reminder of the basic elements of home health. A beneficiary must be homebound and have a skilled need, which includes nursing or therapy to qualify for home health services, and in 2008, Medicare paid for services for about 3.2 million beneficiaries, about 6.1 million episodes for a total of $16 billion in expenditures, and we had about -- in 2008, we had a little over 10,000 providers.

Now, we began with supply, and as in previous years, the supply of providers and the access to home health continues to increase. 99 percent of the beneficiaries live in an area served by one home health agency, 97 percent live in an area served by 2 or more. The number of agencies was over 10,400 by the end of 2009, and since 2002, the number of agencies has increased by about 50 percent, which comes out to about 480 additional agencies a year.

Now, similar to previous years, almost all of the new agencies are for-profit and located in a few states, really in a few regions within states. The concentration of agencies in certain areas, especially those with a history

of fraud and abuse concerns prompted CMS to implement a number of initiatives, but last month several Commissioners indicated that more could be done in this area, and I will say more about that when we come to recommendations.

Next, we look at volume. As you can see from this slide, the use of the home health benefit has increased significantly. The number of users, again, it's reached 3.2 million or about 9 percent of fee-for-service beneficiaries in 2008. The number of episodes has risen by about 50 percent since 2002 to 6.1 million again in 2008, and the episodes per user has risen by 20 percent, implying that beneficiaries are staying on service for longer periods.

For quality, we discussed some issues with the quality measures at the meeting last month. While the current measures suggest a generally positive trend for most outcomes, we discussed several concerns that indicate additional analysis and refined measures may be appropriate.

First, the measures are very broad and do not focus on the skilled care that is provided in home health, and they do not focus on patient types that are most likely to benefit.

For example, the measures here show improvements

in function for all home health users. Given the number of users who receive therapy in home health, it would be useful to see functional improvement just for those patients.

Second, the measures present conflicting trends as they show improvement in the functional measures and no change in the adverse event rates. This disconnect seems troubling, as one might expect that quality care, which improves functioning, would also have a positive effects on adverse events; however, that does not appear to be the case, and we would like to understand the reason for this trend.

Third, some work by a contractor for ASPE raised questions about the accuracy of the risk adjustment for these measures. This research raised questions about the ability of the measures to control for differences in patient risk among agencies, and I can say a little bit more about that if you have questions.

For these reasons, we are being more guarded in our conclusions on quality this year. The current measures do show improvement, but additional analysis and revised measures would be beneficial.

In terms of access to capital, it appears that

home health agencies appear to have adequate access. It is worth noting that home health agencies, even publicly traded ones, are less capital intensive than other healthcare providers. Most home health agencies are too small to be studied by capital market analysts, but for the fraction of agencies that are publicly traded, analysts have concluded that the major firms have access to the capital that they need on reasonable terms.

For the non-publicly traded agencies, the continuing entry of new agencies reflects that smaller entities are able to get the capital they need to expand. As I mentioned earlier, the number of agencies has increased by about 50 percent or an average increase of about 480 agencies a year.

Next, we turn our attention to margins. You can see that the overall margin in 2008 is 17.4 percent, but there is some variation as we've discussed before. The agency on the 25th percentile on the margin distribution and the -- had a margin of about 2 percent while the agency at the 75th percentile had a margin of 26 percent, and this is a spread that we've seen in previous years.

I would note that we only project margins for

freestanding providers. Hospital-based providers, whose margins were included in those reported during the review of hospital payments this morning averaged a margin of -4.6 percent in 2008.

And then, finally, the table at the bottom shows our projected margins of 13.7 percent in 2010. These projections include the effects of planned payment policies including market basket updates and reductions for improvement in coding.

The next two slides address some questions about the range in margins for very rural providers and negative providers.

Questions raised by Tom at the last meeting, but I believe shared by a few other Commissioners. Tom was concerned about the financial performance of providers that serve the most rural areas. In this chart, providers have been split into quartile groups based on the share of their caseloads that come from the most rural areas, those with an urban population -- those counties with an urban population of less than 2,500 people. Though there is some variation, the overall margins for providers that serve these areas was no different than the national average I reported on the

prior page, 17.4 percent.

The agencies in the lowest quartile, those for which very rural patients comprised 1 to 24 percent of their population had the lowest margins with 12.7 percent, while those in the third quartile had the highest margins with 22.7 percent. These margins suggest that even agencies which server very rural areas can earn significant margins under current payment levels.

Commissioners were also interested in understanding how the --

MR. HACKBARTH: Evan, before you leave that, can I just make sure I've got that.

So, as you move down the slide to the 75 to 100 percent, the way I'm interpreting that is that in the agencies in that group are the ones where between 75 to 100 percent of their patients are from the remote areas, if I'm reading that correctly.

MR. CHRISTMAN: Exactly. That's it exactly.

We also looked at the characteristics of negative margin agencies compared to agencies with positive margins, and this slide walks through that.

As you can see, the non-profits tended to be a

slightly higher share of negative -- non-profits tended to be negative at a slightly higher rate than for-profit agencies, and rural agencies tended to be negative at a slightly higher rate than urban agencies.

And then, several Commissioners have also expressed concern about the variation in the margins under the payment system. Remember that in a presentation last November, we walked you through an analysis that examined the difference between high- and low-margin providers. We found that the variation in the home health payment system was about the same as the variation in margins in other PPSs. We plan to do more analysis in this area, but the primary factors we identified were differences in agency cost per visit and, to a much smaller extent, case mix.

Overall, here is a summary of our indicators: Beneficiaries have widespread access to care; the number of agencies continues to rise, reaching over 10,400 in 2009. The number of episodes in rate of use continues to rise, and existing quality shows improvement on most measures but we believe better measures are needed. The access to capital is adequate and margins for 2010 are projected to equal 13.7 percent. For the most part, these findings are very

similar to prior years, and that leads me to the draft recommendation.

The recommendation reads, "The Congress should eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home healthcare services to reflect the average cost of providing care." Now, the spending implications of this are that it would save $750 million to $2 billion in 2011, and more than $10 billion over 5 years. The beneficiary and provider implications, we expect some contraction from the current high level of supply. The remaining supply should be adequate to provide adequate access to care.

I would just note that we expect a change of this magnitude may result in some agencies leaving the program; however, almost all beneficiaries had access to home health six years ago when there were significantly fewer agencies than we have today, and for this reason we expect that access to care would remain adequate, even if supply contracts in the future.

This next recommendation is similar to one we made last year, but we changed it around a little bit to reflect comments from the last meeting. The point of this

recommendation is to set up financial safeguards that would mitigate incentives to reduce services when payments drop due to the rebasing.

The recommendation reads, "The Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from stinting or lower quality of care in response to rebasing. The approaches considered should include risk corridors and blended payments that mix perspective payment with elements of cost-based reimbursement."

In terms of spending implications, there would be some administrative costs, but we expect it be budget-neutral impact on benefits payments.

In terms of the beneficiary and provider implications, we expect that this could potentially improve beneficiary access to care because it would encourage agencies to maintain the level of services they provide, and we don't believe it should affect appropriate access to home health care services.

Also at the last meeting, a few -- let's see -- the other one is -- this is the quality recommendation, and this would charge the Secretary with developing additional

measures by identifying patients who would benefit from home health. This would also address some of the concerns about the definition of the benefit mentioned by Commissioners last December.

It reads, "The Secretary should identify categories of patients who are likely to receive the greatest clinical benefit from home health and develop outcomes measures which measure the quality of care for each category of patient."

The spending implications are that we would expect some administrative costs, and the beneficiary and provider implications are that we expect no impact on appropriate beneficiary access to care or providers' willingness to care for Medicare beneficiaries. It does have the potential to improve the quality of care.

And then, finally, at the last meeting, there was also some interest in some fraud and abuse recommendations. There was concern that CMS and others needed to be more aggressive in identifying and recovering fraudulent payments. It appears that under current authority, CMS has had difficulty addressing fraud, even in areas that have rampant patterns of abuse, such as Miami.

MedPAC and others have witnessed patterns of utilization that are anomalous, such as the significant variation in home health use among regions, suggesting the need for greater vigilance.

With these concerns in mind, here is a draft recommendation that expands the Secretary's authority to act, and it reads, "The Congress should direct the Secretary to review home health agencies that exhibit unusual patterns of claims for payment. The Congress should provide the authority to the Secretary to implement safeguards, such as moratoriums on new providers or suspension of prompt payment requirements in areas that appear to be high risk."

And the spending implications are that there are some administration costs, and it is not on the slide, but last night, CBO sent us some scoring for this that suggested the savings would be somewhere less than $250 million and less than a $1 billion over 5 years for this recommendation. We expect no impact on beneficiary access to appropriate care or providers' willingness to care for Medicare beneficiaries.

Now, another area that came up, and I think this was a concern of Arnie's and perhaps some others, was the

accountability of the physicians in ordering home health, and let me recap a little bit the role of physicians in home health.

Under the Medicare Act, physicians have to certify eligibility and the need for care every 60 days. In the review of eligibility, the physician must certify that, to the best of their knowledge, the beneficiary is homebound and has a need for skilled care. This is a formal attestation, and physicians are liable under the Stark Self Referral Act, the Anti-Kickback Statute, and the False Claims Act for the attestation they make; however, despite the emphasis Medicare places on the physician's judgment and the ambiguity in Medicare's definition of the benefit, there are no requirements that the physician examine the beneficiary in person. They may rely on medical records or other communication to make this judgment. For these reasons, it may be appropriate to require a physician or nurse practitioner to personally assess a patient when making these certifications.

Here is a draft recommendation which reads, "The Congress should require a separately billable in-person visit with the physician certifying or recertifying a

patient's need for home health, and this visit should occur within the 30 days' prior to the episode start, and the spending implications of this -- and again, this is another one where the scoring came in late last night from CBO and they indicated that they expected this would save somewhere less than $250 million in the first year and less than $1 billion over 5. The beneficiary and provider implications are that there be no impact on appropriate access to care and no impact on providers' willingness to care for Medicare beneficiaries.

And then, finally, another issue is ensuring that physicians are aware of their responsibility under the home health benefit.

Prior to 2002, Medicare had a standardized form that physicians had to sign which reinforced their responsibility and culpability when certifying for home health, but this form was eliminated.

Current policy sets forth guidelines for the format of the certification, but they do not lay out a single from. Agencies may use the old form, but they are not required. This creates an opportunity for manipulations that unscrupulous home health agencies may attempt to

exploit. Given that the program counts on physician oversight, ensuring that physicians understand their responsibility and other benefit -- is critical to appropriate use and integrity of the home health benefit.

Reinstating the form is a requirement that would ensure physicians are being consistently and completely informed of their responsibility. And this brings me to the last draft recommendation.

It reads, "The Secretary should require that physicians must complete a standard from when certifying the need and eligibility for home healthcare. The Secretary should develop procedures for reviewing the certification to ensure that physicians are exercising appropriate judgment when certifying home health services."

And the spending implications are that there'd be limited administrative costs. I don't believe CBO had a score for this or expected no score.

The beneficiary and provider implications are that there would be no impact on beneficiary access to care or providers' willingness to care for Medicare beneficiaries.

That completes my presentation. I look forward to your questions.

DR. DEAN: You assume I have a question. Just to start, this has obviously been a concern of mine.

On slide 8, compared with page 38 in the chapter, the table on page 38 -- it lists the range of margins from -9 to 37 percent. These are quintiles and I realize these are quartiles, but there's a huge difference between the 2 percent to 26 percent and -9 to 37 percent.

What is the explanation?

MR. CHRISTMAN: Okay. Right. There are two different measures. What you see on the screen here is the average margin for the agency that is the 25th percentile of the margin distribution. So, it's a single agency's margin.

DR. DEAN: Okay.

MR. CHRISTMAN: And what you're seeing on the sheet of paper is it is a margin for the cost and payments of all the agencies in the bottom quintile. So, there is about, I guess, around 800 agencies in there.

So, that's why what you see there is higher, because it is the very tippy-top of that quartile group, whereas down at the bottom there are a bunch of agencies with -10 and -20 that will be the 1st percentile in the margin distribution.

DR. DEAN: So, looking at the agencies with the low margins, it would seem maybe the -9 is more representative of the group than the 2 percent.

MR. CHRISTMAN: Well, yes, but I guess we're -- and this is a fair comment, but I think what we're just trying to -- we're trying to do -- it's two different ways of showing the margin distribution. I think there's been discussion of what the -- of variations in performance in the home health system, and we've always shown the 25th and 75th. I could show the 10th and the 90th, and you would see a lower number, obviously, on the low end, and a higher number on the on the high end.

DR. DEAN: Okay.

MR. HACKBARTH: I can see why that's confusing. So, you hear the issue that Tom's raising: We need to help people understand when we're subtly changing the measure like that. And I would agree with Tom's statement, that the -9, because it's the average of the whole quintile --

DR. DEAN: It's the composite of the group.

MR. HACKBARTH: -- that is more representative of the group as a whole as opposed to this way of measuring, which, as Evan says, is one agency.

DR. MARK MILLER: Well, just one second on this.

This is the quartile break, and the other one is the quintile break.

DR. DEAN: Quintile break, yes.

DR. MARK MILLER: I mean, if you broke this at the quintile, you could very well come up with a negative number. So, I'm not sure there's a misrepresentation of the actors in that -- I mean, the quintile just breaks it further down the distribution into the negative.

DR. DEAN: I understand that.

MR. GEORGE MILLER: No, and this only includes freestanding, where this one in the chapter is all-inclusive, which would be including hospital base.

DR. MARK MILLER: That's not right?

MR. GEORGE MILLER: No?

DR. DEAN: I think all your margins just include freestanding.

DR. MARK MILLER: Freestanding.

DR. DEAN: Because that was my next issue.

MR. BERTKO: One percentile, one percentile.

MR. HACKBARTH: Yes, yes. The misrepresentation word caught my ear, Mark. And if I understand Evan

correctly, neither is a misrepresentation. They are different statistical measures of the distribution. One is focusing at a particular point on the distribution; in this case, the 25th percentile, and saying, what is the margin of that agency, or the agencies are at that point in the distribution, whereas --

DR, CROSSON: See, it's akin to means and medians.

MR. HACKBARTH: Yes, whereas the other measure is saying, let's look at everybody in the quintile, the lowest quintile, and then average up, take the mean of the people in the bottom quintile. There are different measures, neither is right or wrong, but they are different. There could be some distortion in the comparison by the fact you're using quartile at one place, the 25th, and the other you're using the quintile, the 20th.

DR. MARK MILLER: And I follow all that, and with all respect, all I'm saying is that you could break that at the quintile and you would get a lower number; you could break it at the 10th percentile and you would get a lower number; that's all I'm saying.

MR. HACKBARTH: Yes, yes. Agreed.

DR. SCANLON: I think the more important issue,

though, is that when you do the average for a group that's in the bottom 25 percent or the top 25 percent, you -- there's an influence of what the most extreme value is. And having worked with some of these kinds of data before -- I don't know whether you've done this, but sometimes we would throw out the top five observations or the top ten observations, because they're absurd. I mean, and so you get to this point where you're bringing in data that may be suspect and it's driving that average where it doesn't drive the percentile point.

MR. HACKBARTH: [Off microphone] -- point, and Evan, do you just want to address it? Do you trim the extreme values when you do these?

MR. CHRISTMAN: We do a lot of trimming, yes. These cost reports are not audited, in general, so we clean them out. I mean, there's about 5,000 agencies in our final sample of 7,000-8,000 cost reports that we start with. So, we do.

DR. DEAN: I'll wait for round two.

MS. HANSEN: Yes, thank you, Evan. This is -- actually, the language of all the recommendation threes, and it has to do with having the physician role certified. Is

it specified in statutory language that it's a physician or, given our earlier discussion today about primary care providers, is there -- it is really about having somebody who is qualified, and if it is, in some places, an advanced practice nurse who could be part of this.

MR. CHRISTMAN: I do not believe at this point that an advanced practice nurse can do it. I believe the law specifies a physician.

DR. MARK MILLER: Actually, I thought we were having a conversation, at least based on some of our discussions yesterday, where we were going to try and parallel what we did on the hospice side, where we said "physician or advanced practice nurse." We can recommend what we want, but I did not realize -- you think it's specifically precluded by law for someone to do it.

MR. CHRISTMAN: Well, yes. I think that the current law -- I believe it does not permit a nurse practitioner. I believe it would have to be a physician who does it.

DR. SCANLON: I think there may be a provision in either the House -- I think it might be in the House bill that may expand the numbers of people that can certify, or

the types of people that can certify, but I wouldn't swear to that.

MR. HACKBARTH: I want think a little bit more before I commit to doing something.

The idea of having advanced practice nurses practicing under the supervision of a physician being able to have the face-to-face visit is appealing to me. This was something Ron and I talked about, also.

And so, if we think that they are prohibited from doing that by statute, we could recommend that the statute be altered to accommodate that. So, let's just put a marker on that and continue with comments.

MS. BEHROOZI: I guess it's kind of related, and maybe it's a dumb question, but that physician who does this, does it matter whether it's an employee of the home health agency or a discharging physician at a hospital? And I noticed that in hospice it requires two; it requires somebody who is not employed by the hospice to also make that determination and does that have any applicability in this situation?

MR. CHRISTMAN: The current law doesn't allow -- will allow a physician who is employed, say, as a medical

director. My understanding is the way that this prohibition works right now is that the Stark Act allows for you to -- a home health agency to hire a physician to be a medical director and the -- where the line is drawn is that their reimbursement is not supposed to be tied to the volume or value of any referrals that they send.

Now, in practice, sometimes, the reason a doctor -- a medical director at home health agency assigning for the patient is there may not be a regular physician for them to go to for that person. Some doctors I talk to say -- that are medical directors -- say they don't want to, but sometimes it is what they are called on to do to make sure people get care that they are supposed to get.

MR. KUHN: Two quick questions, and getting really down to weeds here and Mitra asked one of my thoughts here, but on the current coding that's available, current CPT codes, do we think that the current codes have the appropriate descriptors and valuations for them to do this certification process?

MR. CHRISTMAN: I guess, in terms of -- I'm really not familiar enough with CPT to really answer that question. I know broadly that codes exist that allow physicians to

bill for doing the paperwork for home health, for example, and this is one of the rare instances when Medicare does not require a face-to-face service. So, they can get paid to do the paperwork. My understanding is it is not a very frequently billed code.

MR. KUHN: And the second question on the recommendation 3C for that certification, I guess, for lack of a better term, a certificate of medical necessity, I guess, why did that -- what was it replaced with in 2002, or was it replaced with anything?

MR. CHRISTMAN: It was. What it was replaced with was just sort of broader guidance. They got rid of the from and they said, the from needs to -- there's no longer a requirements that you use the -- it was called the 485 -- no longer a requirements to use the 485, but, oh, by the way, here's a bunch of guidance that says when you fill out -- when you take the certification, it must have all these elements look very similar to the 485, and then even that guidance was retired.

And so, it is much more -- broader, higher level statements now that govern what the content of the form is. My understanding is that some contractors rely on the old

from when they're auditing and saying -- telling the agencies what they expect. But the point of this recommendation is just that right now there's a little bit of leeway in what agencies might do and a concern that unscrupulous agencies might seek to manipulate this uncertainty to not fully inform physicians of their responsibilities, and that's what we're trying to close.

DR. BORMAN: Just to try and come at the CPT question, Herb, I think that you could probably use the mandated services modifier that, for example, goes on an E&M visit doing an EMTALA, screening, stable enough evaluation. There's a mandated services modifier, so presumably some application of that could work for that and you wouldn't have to create a new series or anything since it's face-to-face.

DR. BERENSON: We created a care plan oversight code for this purpose when I was at CMS. In fact, my understanding is that it's not billed very much, but at least some physicians are grateful. The idea at that time was, if we're expecting the doctors to take responsibility for this certification, we should at least pay them for their professional services, and it was one of the first CPT

codes -- it was actually HCPCS -- CMS generated one initially, made its way into CPT, one of the few non-face-to-face codes. Whether it's adequate to what we're now expecting, and whether if we start now talking about a face-to-face visit -- whether it should have other things in there.

What I was going to say in round two, but I've got the platform here, is that if ever there's a need for a medical home-like activity, it is having a physician knowing -- in many cases, it's not the primary care physician who is taking care of the diabetes and the heart failure who is requesting skilled nursing. It may be the surgeon who debrided an ulcer and needs wound care, and suddenly there's this form showing up with the medications all wrong. The surgeon is doing what the surgeon is doing. There is a need here for real coordination, preferably, in my view, through the primary care physician, but it can be another physician taking responsibility, and it should be paid adequately, and we need to get code descriptors that are specific for this activity in my point of view.

MR. GEORGE MILLER: In general, I support the recommendations. I'm a little bit concerned for rule and

frontier hospital-based home care. I think you made the comment that most of the beneficiaries in America would not be affected; however, in those remote areas of the country where the hospital-based home care may be the only provider of care -- well, I should have asked that question.

Do you know if you can identify those places in America where the -- other than Tom's -- where the hospital provides all of the home care for a community or a region or whatever the descriptor would be, and how many there are and how they would be impacted by this regulation, particularly since they are the ones, I believe, with the negative margins?

MR. CHRISTMAN: Okay. So, there are a couple of questions in there, and let me make sure I get them all.

MR. GEORGE MILLER: I only tried --

MR. CHRISTMAN: One is I believe there's about 1,300 hospital-based agencies, and we can see where they provided are in a given year. Let me back up.

It is always challenging to figure out what a home health service area is, because we can run the tapes and we can see where they provided are, but obviously their service areas could extend to places where people didn't live or

didn't demand services. So, we -- it's not a perfect process with that.

In terms of how this would affect their margins, obviously it would be challenging for them. I think the difficulty we -- the thing that really trips me up with hospital-based agencies is they have a higher cost per visit than freestanding agencies, and it's -- the number off the top of my head -- can't summon it, but trying to understand why it cost them more just to provide a visit in the same side of care that a frontier operating freestanding agency would go to is something that we've never really been able to satisfactorily explain. And so, I appreciate that this is going to have a higher -- they have negative margins, so it will hit them, but we see another cost structure that operates in the same environment that, as you saw in the next slide, was getting the same margins as providers overall.

So, I guess that's why I think that obviously the draft recommendation is perhaps in the right place, but the difference in --

MR. GEORGE MILLER: But I guess my question, I'm sorry -- is, are there -- do you have the number where they

are the only provider of that service area.

MR. CHRISTMAN: I'm sorry, I don't know that. I don't know that.

MR. GEORGE MILLER: And with this recommendation, how many will we put out of business, because the commercial providers aren't covering that role of small frontier?

Even though I agree -- I mean, I believe you that the difference providing that care may be different but if they are not providing that service in that community, you're going to leave them without any services, and I think this is Tom's point, yeah.

DR. DEAN: I mean, just speaking to that with the South Dakota example, South Dakota is a pretty big state. The only freestanding providers that exist are in two corners of the state, in Sioux Falls and the Black Hills area. The rest of the state, the only providers that are available are hospital-based.

MR. CHRISTMAN: Yes, I mean, I guess that what we don't understand well enough is why there are some areas that are very rural that are going to have a freestanding agency and some areas that don't. And what we know about the freestanding areas -- excuse me, the frontier areas

where a freestanding area will operate is that they can take a lot of patients from these areas and they can do pretty well. And maybe we owe you a better path at that question, but it doesn't suggest to us that -- I guess we don't have an obvious answer as to why they're avoiding those areas, because there are areas that are that sparsely populated where they're diving in and doing all right.

MR. HACKBARTH: I just want to go back and ask a question about something you said. So, you said, when you compare the per visit cost of the hospital-based agency and the freestanding, the hospital-based are significantly higher, are you talking about average costs, including the allocated overhead when you do that calculation?

MR. CHRISTMAN: Yes, yes.

MR. HACKBARTH: Okay. So, if you're including the allocated overhead, it pretty much explains why the per visit cost -- or at least part of the reason why the per visit cost is higher.

Now, if I'm running a hospital-based agency, the question that I'm asking about whether I want to continue this line of business or not is whether my direct costs are covered and whether this operation is contributing to my

overhead costs. And so, even if on an average costs, fully allocated basis, it's losing money, it could be a good thing to continue to do if it's helping the hospital spread those fixed costs over a larger base, and can we shed any light on that?

MR. CHRISTMAN: We haven't done that analysis. That's something that we could look at.

DR. MILSTEIN: I have a frame of reference question. If you were -- can someone else remind me whether or not the physician who is authorized to do the certification for hospice eligibility, do we allow that physician to be on the payroll of the hospice, because obviously -- you know where I see this question is leading.

DR. MARK MILLER: Yes, I do, and Glenn and I were talking a little bit offline. We may have more to say about this, but I believe the following is correct: When the initial certification is done for the patient for hospice, it is supposed to be a community-based doc involved in that with a hospice-based doc. Well, after that point, it can be just a hospice-based doc.

Did I answer you question? I thought that I did.

DR. MILSTEIN: Let me ask the follow-up.

In our last discussion in December we talked about what -- given what we know about this area, whether this might be something else we might layer into either A, B, or C -- it could go in any of these places -- about essentially saying that the physician doing the certification cannot be on the payroll of the home health agency.

Could you just share the rationale for not doing that.

MR. HACKBARTH: What gave us some pause there was thinking about integrated systems where there's common ownership, a physician on the payroll, a salaried staff member of an integrated system that also owns the home health agency. So, it is those sorts of cases.

DR. CASTELLANOS: I guess on page 19, I just want to really make sure that I understand this.

The physician -- I hope it's not an either/or situation where the physician is certifying or recertifying. I would hope that could be the same physician. It can't -- he doesn't have to be one that just certifies and another one that doesn't. It is just semantics that I'm concerned about.

MR. CHRISTMAN: Well, there's some interesting

transition of care questions that come up around that exactly. And this -- for example, is someone coming out of the hospital? Maybe in an ideal situation they're being returned to their -- the community physician will take over. But in terms o moving the -- getting home health to that person as soon as possible, you might expect that the hospital physician will certify that, and then maybe the community-based physician would recertify. Now, maybe that's not an idea situation and that's something to talk through, but that's -- the current approach does allow some flexibility and I guess it shouldn't be thought of as all bad, necessarily.

DR. CASTELLANOS: What you are saying, the mix, and the hospital and -- just to stress, Glenn, your point is that, as far as a physician goes, if it is by statute, it has to be a physician, I think we need to make a recommendation to change it to that statute.

MR. HACKBARTH: We'll come back to that. Mark has some clarification on that.

MR. BUTLER: So, once you get past the update recommendations, we're saying, Secretary, we want you to do something, we're going to authorize you to do it, and so

we're trying to guess with as great as precision as we can on some of the options, and that's where we're struggling a little bit here.

But I have a couple of clarifying questions. So, there's 86 -- and your slide 8, I think, it says 86 are for-profit -- 86 percent, 14 percent non-profit of the freestanding, although the same chart in the chapter does not say that these are just freestanding.

So, is that about the right -- the chapter of documents says that 86 -- it has some of the same numbers, but it doesn't say it's just freestanding.

MR. CHRISTMAN: Yes, no. They're just freestanding in the --

MR. BUTLER: So, if you added in the 1,300 that are hospital-based and that --

MR. CHRISTMAN: That are for -- right, I'm sorry. Go on.

MR. BUTLER: -- they're not all non-profit, either. Probably some are associated with for -- I'm just getting a sense. Is it roughly --

MR. CHRISTMAN: It would -- I think the share of non-profit would rise.

MR. BUTLER: Right. So, it might -- but it is still predominantly not -- my next question then would be, going to page 17 and the recommendation.

So, I'm curious because we've discussed in various settings various ways -- maybe the inspector general isn't one to look after this in some way, but in -- I think it came out of 41 investigations in Dade County alone, would you know anything about whether those are almost exclusively for-profit, the generated ones, or are the non-profits been the source of some of these, too?

I'm getting at the moratorium. Maybe this is an example of where we should have a moratorium maybe on the for-profit side of this if that's where all the problem is versus the non-profit.

MR. CHRISTMAN: Well, my understanding is that most of the troubles that they have found so are in non -- or, excuse me, for-profit agencies. That's not to say that they may find something else coming down the line, but I guess that's -- in terms of the facts, that's what I know.

MR. BUTLER: I would just hate of us to throw out there, well, let's have a moratorium on everything if in fact where you see this coming up is in a specific segment

of the business.

MR. HACKBARTH: Yes, and I understand what you're saying.

When I look at this recommendation, what I see is that we're urging Congress to broaden the Secretary's discretion, give her more tools to use where investigation identifies problems.

One of the things that presumably she would want to do is examine these patterns.

MR. BUTLER: I understand. It says "such as," too. It doesn't say this one specifically.

MR. HACKBARTH: Right, right, right.

Do you want --

DR. MARK MILLER: And just -- yes, I will. And just the other clarification, it says, new providers, and the growth in this area has been dominated by for-profits or not?

MR. CHRISTMAN: Oh, yes, absolutely.

DR. MARK MILLER: So, you may be closer to where you wanted to be, anyway.

MR. BUTLER: As long as we make sure -- and I think the chapter does say this. It helps steer them in a

direction where to look, then I think it's fine.

DR. MARK MILLER: And that can certainly be written about.

MR. HACKBARTH: Okay. So, before we go back and start round two, I want to address the issue of the physician/advanced practice nurse in making the certification.

Mark.

DR. MARK MILLER: Okay. And I need eye contact with Kim and Evan, okay? Since I've been kind of tired here and missing --

MR. HACKBARTH: You need to be wall-eyed, I think, to do that.

DR. MARK MILLER: All right. Okay. So, what I'm suggesting here -- could you put up 3B. Sorry about that.

So, what I would suggest here is we, in the second line, take out the clause that says "with the physician." So, what this becomes is a separately billable in-person visit certifying or recertifying, okay?

And so, this would leave the flexibility for that visit to be done by a physician or a nurse, advanced practice nurse, and we would continue to be fairly -- or be

consistent with our hospice approach.

And what would be important to add to that is that -- and this is also consistent with the hospice approach, assuming I've still got the right eye contact here is, in our next recommendation where it says "somebody must certify," it does have to be certified by a physician. So, in other words, you could have an advanced practice nurse go out and visit the patient and come back with notes and so forth about the condition of the patient, but the certification in the end is by a physician.

So, 3B would be the visit can be made by either/or, or a set of people, 3C would be, but the certification is the physician only, and I believe that's consistent with the tact we took in hospice.

Okay. Even, I realize this is a switch while you're right up at the plate. So, if you have reactions, the time is now.

MR. CHRISTMAN: I think that that follows what I expected it to do.

MR. HACKBARTH: Bob, on this issue?

DR. BERENSON: Yes, on this issue -- I'm thinking out loud here a little bit. What I think happens in -- I

mean, where's the other one?

DR. MARK MILLER: 3B.

DR. BERENSON: 3B.

So, you would say, Congress should require a separately billable in-person visit certifying -- I mean, the issue is when -- if things were working well and you had a medical home physician practice and the patient was seeing, let's say, a surgeon for a procedure for a debridement and that surgeon thought the patient needed skilled nursing and home health services, that that would constitute the visit and that that primary care physician wouldn't have to separately see but was able to certify or somebody working -- so, this is not saying the visit has to be done with the physician who is -- or with anybody who is certifying. It's saying a visit has to be done, right?

I mean, I want to give some flexibility, and at the same time, I'm worried that we're opening the door for something here. I mean, if it were working well -- if the medical home could have that conversation, understand the purpose for the home health but not be the one who was actually seeing that patient in that 30-day window.

DR. MARK MILLER: As I understand, what we just

constructed here, the scenario he talked through would be allowable. I would have gone to a surgeon, the surgeon would have said, you need -- after this, you need home health visit, and either that visit could certify or another physician could certify on the basis of the information.

Kim, are you having a heart attack.

MS. NEUMAN: [off microphone] No.

DR. MARK MILLER: Okay. I just need to know. I can't always read you.

DR. SCANLON: Yes, I think we have to worry about -- that the perfect does not exist and the medical home is not available to a lot of people and that a MedPAC meeting sometime down the pike could be talking about how dual eligible, other low-income people, minorities, are not accessing home healthcare because they can't get, in a timely way, at least -- they cannot get this physician visit 30 days before the episode starts. There's a particular problem for people that end up hospitalized because the hospital is a source of care of last resort. They don't have -- and they don't have a usual source of care or they use a community health center, they are not going to be able to necessarily get the home healthcare they need the day

they leave the hospital, unless it's the physician in the hospital that plays a role in the certification. And I think we should, at least in the text, talk about that as an expectation. There is a condition of participation for hospitals about discharge planning and this should -- there should be a consideration that you just don't say to people, check off a box, you should go find home healthcare. You should help support them in terms of required documentation.

Now, let me just say that I know from the advanced nurse practice nurse community that they very much feel that they should be able to certify here, and I have mixed feelings about that. I mean, on one level I think it potentially is perfectly appropriate because we're not talking about the same kind of decision that we're talking about in hospice care.

With hospice care, we are talking about something that is much more medical, and here we may be talking about something that is much more related to nursing and they may be in a better situation to talk about -- particularly if it comes to the plan of care -- is this appropriate or not, as opposed to a physician looking at that.

At the same time, we've got this issue that we've

had such loose oversight of home health agencies, I worry about affiliations. I mean, it's not that physicians are all to be trusted and nurses not, it's this question of, we've got to have adequate oversight, and our only line of defense at this point is the certification process, and it's not really an adequate line of defense.

MR. HACKBARTH: Where do you come down on what to do, Bill?

DR. SCANLON: I don't know. I mean, I'm really torn by this.

MR. HACKBARTH: So, I think Bill has made a good point. The decision about the prognosis and whether a patient has six months to live -- that is a physician's decision, whereas certification for home health, I would think could be appropriately be done in many instances by an advanced practice nurse. I do think they're a little bit different, it seems to me, as a non-clinician.

We're making this increasingly complex. My inclination would be to use the language as modified by Mark and have some discussion of this in the text.

MS. HANSEN: I can hear, definitely, what was said by Bill, and the difference with hospice and home healthcare

is there.

I do like the way Mark has characterized it, and then I want to offer one more way to think about this is the aspect of home health in the future will be possible through whether it's an ACO or a medical home will have opportunities for people to get home healthcare appropriately, perhaps not just from the hospital. So, if that's the case, then it's not always going to be the surgeon who sees this wound care that is absolutely necessary. It is going to be based on the functional and clinical needs of home health traditionally that could be ascertained by a skilled person who is an advanced practice nurse, with ultimate, at this point, if it is statutory, still signed by being connected to a physician. So, I'm just looking at it, frankly, also from a beneficiary side that, beyond what was talked about access issues, but there is just a flow of care that should be timely, clinically appropriate, and have accountability to it.

So, I think what Mark does offer right now offers us that room plus the text.

MR. HACKBARTH: On this issue of the availability of the visit, I think given the issues around access to

primary care, that is, as Bill says, a legitimate concern, and allowing an advanced practice nurse to do the visit if not the certification, does at least somewhat expand the pool of available clinicians to do this piece of work.

DR. DEAN: As you and I talked about on the phone, I hate this kind of stuff. This, I think, it's --

MR. HACKBARTH: You're talking about certification of home health, not MedPAC meetings.

[Laughter.]

DR. DEAN: Not MedPAC, no.

MR. HACKBARTH: Be clear.

DR. DEAN: I think if we're going to go in this direction, we have to have some explicit criteria as to who qualifies and who doesn't and some guidance. If we're going to sign a from with some significant accountability, we need to know what it is, who are we supposed to certify, and who are we not.

And I guess I'm reacting to the certification for DME stuff drives us crazy, because we get these laundry lists from the supplier about the diabetes supplies, and they include everything you could think of on there, and the easiest thing is just to sign the form, but that authorizes

the provider to deliver all kinds of supplies, and I have people coming in to -- well, I've got this meter that -- I don't need a meter. And it gets even worse when you get into some much more significant equipment like scooters and wheelchairs and that kind of stuff.

So, I think that the idea that, in some ways, an in-office visit might be the least valuable in terms of trying to make this judgment, what we need is knowledge of what is this person's functional capacity at home; can they make a legitimate decision about their medications; are they truly homebound and what does that mean; can they go to church; can they come to the doctor; can they get their groceries. And those are the things that we're supposed to verify with a certification, and frequently we may not know. So, like I say, I cringe a little bit, even though I understand that somebody needs to make that judgment, but it needs to be someone that really knows what that person's capabilities are, and a visiting nurse probably knows better than we do. And so, either we need some direct information from them which sometimes we get and sometimes we don't, but anyway, that's my frustration.

DR. MARK MILLER: You are tracking that that's an

in-person visit. So, the way this is constructed, a nurse could go to the home and gather that information.

DR. DEAN: If we had a good clarification of what information we really need and what are the criteria, it would be much more doable.

MR. HACKBARTH: [off microphone] -- some of the same concerns that Tom has, and then Bob, who has thought about this a bit, then Jay. So, let's do some doctors for a while.

DR. BORMAN: I think part of the problem we're now coming back to, and I'm very happy with Mark's modified language, because I think it's flexible, we can cite some scenarios and be a little bit vague, but the problem we're bumping up against fundamentally is we don't have a good definition of this service. That's the problem. Since we don't have a good definition of the service, all the roll-out from that about what you should do in order to enable it, who should do it, how it should be done becomes very difficult because you don't know.

For example, if I look at it from the perspective of a practicing surgeon, as I look at home health, there is basically a dichotomous population of visits. One is very

sharply delimited for the most part, almost mono-task focused. The individual, for example, that has a wound in a location on their body they can't reach that needs regular dressing changes, and at X time, the wound is going to heal, or maybe the other thing they have with it is the administration of preventable antibiotics. So, they get a shot, they get an IV, something, while the caregiver is there. That's pretty definable. That probably is better served by being the person who is going to make the judgment about that wound and it's healing and whatever, and I will say that it's been my observation that many of the forms that come to me under these circumstances have these people getting wound care twice a day for weeks on end or they're getting their wheelchair certified for 99 years or whatever the longest thing it is on there so they can have it indefinitely. And so, I find that what comes -- and typically, those are -- other than physician advanced practitioners that are filling out those forms upfront, and I think they are somewhat hobbled by their limited information about the patient when they go to fill out the form. But I do think part of the problem is we don't -- we haven't defined the benefit.

And we really have two kinds of benefits. We have this rather finite, shorter-term, mono- or duo-problem focus, and then we've got this person over here who is 85 years old, has 5 chronic illnesses, 22 pills a day, it's starting to get into an issue of medication management. They really do need their blood pressure taken two times a day, whatever it may be, and unfortunately, in my part of the real world, to use Ron's phrase, these people come with paperwork that looks very similar. The 33-year-old with the wound he or she can't get to comes with a form that says, take vital signs twice a day and visit them four days a week for four weeks and da, da, da. So, I think we're fundamentally at the problem of defining the benefit, which in some way we're turning back around to the Secretary, and so maybe we need to be careful just how far down this detail road we go so that we don't preclude the opportunity to redefine rebase.

MR. HACKBARTH: Before I turn to Bob, you said at the outset, though, that you felt that Mark's modification....

DR. BERENSON: Yes, I think we will want to continue this sometime in the future because this is -- let

me just agree mostly with Tom and Karen on the frustration around this benefit.

I would consider myself, when I was in practice, relatively policy savvy. By some standards, I was already a policy wonk. And I had no clue as to what I was signing for what purpose. There may have been a form that instructed me, but I did not know that the patient needed to have a particular skilled need, whether it was nursing or therapy. I didn't ever hear the term home-bound, that is supposedly there. I just knew these forms were coming in front of me, usually with the wrong medications. They had been filled out in the hospital. And by the time it got to me, usually for a recertification, all of medications had been changed without any opportunity to get involved.

So I like the fact that you have put in the chapter that there's a real issue here. I think we're going to have to go beyond just reinstating a form or something. I think there's got to be a real education activity associated with -- if, in fact, we are going to continue to see the physicians or advanced practice nurses as the gatekeeper for home health.

It is important enough, it seems to me, with the

kind of money that we are putting out the door and the clinical services being provided, probably for as much as you don't know that -- I mean, all these things are happening and you have no control. I think we want to force the physicians, somebody, to actually take responsibility in this area.

I learned towards the end of my practicing career the way to deal with this often was actually by spending the time talking to the home health nurse -- who loved talking to me once I finally figured out that that was a possibility -- to find out what was going on with this patient. I started taking responsibility to understand what the surgeon was ordering.

And it is the concept of the medical home, and I agree with Bill, it's going to take us a long time to have medical homes around the country. But it does seem to me, if we can't start here -- and compensation has to be part of this -- to ask for a serious professional effort by medical practice to take responsibility for complicated patients in home health, it's got to be paid appropriately and held out as a very important professional service. And if that means the time to be on the phone with lots of people, then that's

what we want to be doing.

That's different from the whole medical home infrastructure that we're talking about. But I think, as an interim, we could probably create some CPT codes and, with education, I think make some good progress.

I share with Arnie some concern about physicians who are sort of double agents in this area, who are also working for the agency. I don't have a way out of this integrated care system. But an integrated care system that's doing fee-for-service only makes me nervous. But I understand there's no easy way to get around that.

So I'm comfortable with all of the language. I think, if anything, we want to strengthen what you've already put into the text on this physician -- on education, on reinstating the forms, and on paying appropriately for what's a very serious professional activity.

DR. CROSSON: I agree with everything that Bob has said. I have a similar vision. And I think with the combination of recommendations 3B and 3C, we very well could get there.

However, in addition to taking time, I'm also

concerned that maybe that's not going to happen everywhere. We already have evidence that because the benefit is ill-defined, and for other reasons, there appears to be progressive overuse of the benefit.

So I've sort of come to something that I never thought would escape my mouth, and that's the possibility of preauthorization. I have been, as a physician, generally quite reluctant to see that used because I don't think it's very successful. However, there are some characteristics here which are a little different.

First of all, we've already described that, in fact, this benefit could be adjudged by someone other than a physician. In fact, some have made the case maybe it should be done so by someone other than a physician. So it's a little different from some of the areas that preauthorization has failed in, I think, in the past.

By the way, I'm going to speak against preauthorization tomorrow in the quality discussion, just for the record.

[Laughter.]

DR. CROSSON: I don't think we should muck up recommendations 3B and 3C with that, however. So I have one

suggestion, and that's on recommendation 3A, on slide 17, that we consider inserting in the panoply of actions that the Secretary could take in situations where things seem to not be working to institute independent preauthorization and perhaps in certain geographies at certain times, and perhaps something could be learned from that. It either would work as a temporary solution, a focused solution, or it wouldn't.

So my proposal would be to insert after the word providers on line four "comma, independent preauthorization."

MR. HACKBARTH: Okay. Herb.

MR. KUHN: Just one general thought here that might be helpful is we talked about putting additional things in the text that might be available here. One model that we might want to look at or explore is about three years ago CMS did get rid of the certificate of medical necessity for DME because of all of the problems they were having with wheelchairs and powered mobility devices.

So that model, that process of education, redefining, educating the physician community, et cetera, might be a model that could be amplified in the text of the report, to help us kind of understand.

MR. HACKBARTH: Just say a little bit more. You say CMS got rid of it?

MR. KUHN: They eliminated the certificate of medical necessity and replaced it with a physician just regular prescription for the product or the device and services, and I think went through a national coverage determination for better clarification of what the benefit really was.

At least to my recollection, that seemed to clean up that space, or helped a lot in terms of better defining what was out there.

DR. DEAN: I still get requests to sign the blamed thing.

MR. KUHN: Now I will tell you, some suppliers have created your own and said here's what we want you to sign as part of the process, and that is a way of dealing with it. But the Agency itself got rid of it and went this different way. But some suppliers go ahead and create their own form that they feel will protect them in terms of ordering. But it's still a physician prescription in terms of the process.

So it's something, a model that we could look at.

MR. HACKBARTH: What I would like to do is -- Ron, did you have a comment? Go ahead.

DR. CASTELLANOS: To get somebody on home health, in the hospital you have to write an order. In the office you have to write a prescription. So you have to authorize it by a physician.

My only comments are very similar to Tom. It is a frustrating issue. Fortunately, we have a large practice, I have 10 people practicing. And we allocate all of those material to a nurse practitioner who predominantly we trust. And it's a lot easier for us to allocate that to that one individual who really looks over everything to make sure.

You know, if you look at page 21, 3C, I think we're covering ourselves here by saying the Secretary should develop procedures for reviewing the certification to ensure that the physicians are exercising appropriate judgment. So we have that already in line.

DR. MILSTEIN: I would just like to speak in favor of Jay's suggestion. I think if you then think about the array of such as, I think it would cause some of the marginal or abusive players to think twice because now the Secretary has a variety of stated tools, not tools that

later the Secretary has to overcome industry opposition to initiate. So I think it's a very good idea.

And what's nice about it is we're not instituting it across the board, which would obviously be a nightmare from a physician autonomy and cost perspective.

MR. HACKBARTH: Okay, we have got a number of different things laying on the table here, some of which I think I hear agreement we ought to try to capture more in the text, as opposed to in the bold-faced recommendation.

What I'd like to do is just start going through the recommendations, the first couple I don't think have any pending modifications. Once we get to some of the others we can talk about specific amendments.

So let's put up recommendation one and go ahead and vote on recommendation one. All in favor of recommendation one? Opposed? Abstentions?

Okay, let's do number two. I don't think we have any pending modifications on this one, so all in favor of recommendation two? Opposed? Abstentions?

And then 2B, I think, is good as written here. So all in favor of recommendation 2B? Opposed? Abstentions?

Okay. Now 3A...

DR. MARK MILLER: This is Jay's idea here. So if you wanted to include that, put your eye on the next to the last line where it says "such as a moratorium on new providers, preauthorization, or suspension of prompt pay requirements."

MR. HACKBARTH: Okay. Any discussion of that language? Any clarification needed?

As Peter has noted, these are all such as, these are examples, as opposed to specific requirements.

Okay, with that amendment, all in favor of 3A? All opposed? Abstentions?

Okay, 3B. Mark?

DR. MARK MILLER: Cast your eye to the second line where it says "visit with a physician" and you take out the clause "with a physician." It would be a billable in-person visit certifying or recertifying, et cetera. So we just take out the three word clause "with a physician."

MR. HACKBARTH: Any clarification required there?

DR. SCANLON: The clarification is if it's a visit certifying or recertifying. And then we're saying that a nurse practitioner cannot be the certifier. What does that

mean? That means that it's got to be a visit with a physician, doesn't it?

MS. BEHROOZI: You need a few more words, like "in connection with certifying" or something like that.

DR. SCANLON: Or as I've been thinking here, if we do set up a code for this and we compensate for it, inappropriately certifying can be a false claim. We do have tools to deal with that. So the question of nurse practitioners certifying may not be as problematic as we might think. An agency and a nurse practitioner are going to be at risk for false certifications.

A bit part of this is how much oversight you give to this effort. And I'm thinking that in the prior authorization -- if I'm the Secretary, I'm going to have to worry about the resources to do that, though it's a good idea if we can do it. The same thing is true here. The physician or the nurse practitioner is not a great line of defense unless we have enough oversight to make sure that they're doing their job right. And we have that language in 3C, and I think once we've got that language there it can be either the nurse practitioner or the physician.

MR. HACKBARTH: Pardon me, Bill, my mind is

starting to go here, starting to skip.

Correct me if I'm wrong, Mark, but I think the intent of deleting the "with the physician" language is to open up the possibility that the face-to-face visit will be with a non-physician practitioner like an advanced practice nurse.

DR. CROSSON: [off microphone] Right but the visit doesn't certify.

MR. HACKBARTH: Right, the certification is in the next recommendation and that needs to be done by a physician. What I heard before is that's true with hospice, the certification is done by a physician. And the ensuing recommendation would say would also be done by the physician here.

So we're separating who does certification from the visit.

DR. CROSSON: But I think the issue is if you just take out "with the physician" then it reads that the visit certifies.

MR. HACKBARTH: Okay.

DR. CROSSON: One suggestion would be a language that would say require a separately billable in-person

visit, leading to a certification or recertification --

MR. HACKBARTH: Okay.

DR. BERENSON: I was going to say supporting a certification or leading -- something like that. That would solve my problem, two different professionals coordinating the certification.

MR. HACKBARTH: Okay. Read that again, and then we can ask for clarifications.

DR. CROSSON: It would say Congress should require a separately billable in-person visit, leading to a certification or recertification of a patient's need for home health, et cetera.

DR. SCANLON: How about to assess certification or recertification?

MS. BEHROOZI: I like supporting.

DR. SCANLON: Supporting. Leading to, I'm not sure about that.

DR. CROSSON: Supporting, all right.

MR. CHRISTMAN: I think there is, if I could, maybe this language should read Congress should require a separately billable, in-person examination before certifying or recertifying. I think that captures what you're saying?

DR. SCANLON: I think there needs to be a connection between what's going on in the visit. It can't just precede, it has to be with the intent of working on the home health certification.

MR. HACKBARTH: How about a billable in-person visit --

DR. SCANLON: Supporting.

MR. HACKBARTH: -- to support certification or recertification of home health.

Tom, you look like you're perplexed.

DR. DEAN: It seems to me we're trying to describe the mechanism of how to do it but we're still not clear on what we're trying to get done. In other words, what is it that actually qualifies a person for this service?

They bring somebody into my office who's kind of frail and maybe in a wheelchair and maybe a little bit mixed up, and they sit there, and I've got some kind of vague history. And then I'm supposed to sign this form, do they qualify for home health?

Well, I don't know. And that's the position we're in frequently.

That's why I say we need the criteria as to what

it is that qualifies a person, and then we can make a judgment. But right now, at least my experience is those criteria are so vague that we make a judgment and, in a small community like mine, well, grandma wants the services and the family wants them to have the services. And if I don't sign it -- and especially as we get back to the DME thing, the providers are not above saying well, we would be glad to provide this service, but your doctor wouldn't allow us.

That's why I say, this is not a fun activity. So we need some criteria and I don't think this gets us there.

MR. HACKBARTH: So earlier Bob had made some similar comments about how we've got an educational task here. I would agree that requiring a face-to-face visit in and of itself does not solve that problem. What it may help with, though, is some of the more blatant fraudulent activity where people are being certified for home health without any visit. It's just people writing forms, signing forms, no face-to-face visit, no update on the patient's status. And to require a face-to-face visit makes that sort of inappropriate activity more difficult.

But it is not a total solution to the problems

that you've identified. It's not a solution at all to the problem you've identified.

DR. DEAN: And the problem is the physicians who are inclined to be a little bit loose about this are not bothered by it, and the conscientious ones are the ones that get all uptight about it and are the most frustrated. And if you talk to primary care docs, it's this kind of stuff that they find most frustrating about today's primary care.

DR. BERENSON: I think the problem is we don't have a long-term care benefit in Medicare and, in fact, you are caught in the middle. I mean, the patient's got to be homebound and they're supposed to need a skilled service. And the fact that they're just frail and need support doesn't qualify them for the home health benefit.

And I was there, too, and appreciate the dilemma, but I think it goes to the law and that there's no quick fix to just -- I mean, if we gave you great clarification, my hunch is you'd have to say no more often than you want to say.

DR. DEAN: Probably so, but at least then we can blame it on Medicare.

DR. BERENSON: Okay. That goes to my point is we

have some clear guidance for physicians so that they can say no.

DR. DEAN: [off microphone] Yes, that's exactly what I'm after.

MR. HACKBARTH: What I'm thinking right now is we make the modifications we've discussed in this language and we include a passage in the text that talks about the situation Tom has described that's awkward for the physician. In fact, make the point that Bob has made, is that actually there is some definition here in this benefit, that the patient requires skilled service and be homebound, and what we need is educational activity in support of physicians to apply the benefit as the law is written. And we can handle that in the text.

DR. CROSSON: I think there is an opening for that here in draft recommendation 3C, which asks the Secretary -- it doesn't exactly, but it implies the Secretary will develop a standard form that the physicians would use in certifying the patient.

That form itself could be constructed in such a way as to guide the physician in terms of what the Secretary believes are the appropriate criteria for certification.

And we could put that in the text.

DR. DEAN: I agree, but we should put in there that the form should specify the criteria, because it might just specify the penalties for signing a fraudulent form and that only makes it worse.

DR. CROSSON: But that's what I was saying, Tom, is that in constructing the form, the form could be constructed in such a way as to guide the physician towards the correct --

DR. DEAN: But we need to specify that it not only specifies the responsibility and accountability, it also specifies the criteria.

DR. SCANLON: Okay. I am in total agreement that we have to have this educational effort here to make this work, but I guess this discussion has led me to think about 3C some more and ask the question of should we be limiting it to physicians?

In some respects we have an inefficient process if we do. What we do is we're going to have this visit where we're gathering information --

MR. HACKBARTH: Just for the sake, so I'm sure I'm understanding, you're raising the question of whether it

ought to be a physician that has to do the certification?

DR. SCANLON: Right, because what we've done in the visit, 3B, is we've said that the nurse practitioner can do the visit, gather the information, make the assessment, come, and then present this to a physician who is going to make the decision.

There's two questions about the physician or two issues about the physician that you would want to answer in terms of why it should be the physician. One is that there's something in their medical training that makes them uniquely qualified to make this decision. We've talked about maybe it's not because a lot of this is nursing services.

The second potential reason why we want the physician to do it is because the integrity of physicians is higher than the integrity of the nurse practitioners. And I don't think we want to say that either.

For an efficient process here, to take a burden off physicians so they don't have to learn this, all of the rules here -- and that's not disputing Tom's point -- we need to clarify this. But once we've clarified it, somebody has got to learn this. This is not going to be something

that's intuitive. So there's got to be an educational process. If we're being efficient about, it we're thinking about trying to invest in appropriate oversight but not overspend on oversight, I think we need to simplify this process and have a trained professional, qualified professional -- physician or nurse practitioner -- do the visit, do the certification, and then whoever does it is accountable.

MR. HACKBARTH: So my understanding here, Evan, is that the law currently requires that a physician do the certification. So Bill is proposing that we incorporate in our recommendations a recommendation to the Congress that they modify the law to permit non-physician clinicians to not only do the in-person visit but also do the certification based on appropriate guidance from the Secretary about what is eligible for the benefit?

Let me see hands of people who would like to make that modification to allow non-physician clinicians --

DR. KANE: This is an update day, I guess. And I guess we're getting off into something that really we didn't have the background to get into. And it sounds like the more we talk, the more we feel we don't have the background

to decide.

I don't know how it's done -- you know, we need some kind of overview of how it's done now, and maybe some focus groups on how it should be done.

I don't feel this belongs in the update discussion at the level that we're trying to get to right -- I'm just getting very uncomfortable and trying -- I know Mark's paying everybody here to make this go longer so he wins that bet but....

MR. HACKBARTH: [off microphone] He's already won.

DR. MARK MILLER: [off microphone] So sorry I made that bet.

DR. KANE: I just feel the longer we talk about this, the more complicated it is, and the more I'm sitting there going I don't really think we know yet what we want. And I don't know how clear the guidelines are now.

This sounds like a whole chapter in itself on how do we make sure that home health is used appropriately? And how do we define this benefit better? Then how do we institute the procedures. And I don't think -- if we can't -- to me, this isn't the tail end of an update kind of discussion.

I'm sorry, I just had to get that off my chest.

MR. HACKBARTH: That's a perfectly legitimate concern. We actually did not have this December and we added these additional features in response to the December discussion. But Nancy's right, we're going deeper and deeper into detail.

So one approach would be for us to take -- let's see, the issues are primarily in the 3's, the 3A, 3B, and 3C.

DR. MARK MILLER: Well, B and C.

MR. HACKBARTH: Yeah. Put up A for a second?

DR. MARK MILLER: That's the Secretary checking the pattern.

MR. HACKBARTH: A really is freestanding. A could go ahead on its own. But hold B and C in abeyance until we can work through the issues more carefully.

I see a lot of nodding heads on that. Does that make sense to people? Anybody have strong objections to that? Okay, that's good for me.

Did we vote on 3A already? Yes. So let's skip over B and C, and I think that means we're at the end.

DR. CROSSON: Should we pull the text associated

with B and C also?

MR. HACKBARTH: Actually, let us think about that, but I think it might good to raise the issues and then come back at a later point to make recommendations.

DR. MARK MILLER: To have it, that's what I'm thinking.

MR. HACKBARTH: Okay, thank you, Evan, and thank you, Nancy.

Okay, we are to the public comment period.

Seeing none, we are adjourned, and I won.

[Laughter.]

MR. HACKBARTH: We will reconvene at 9:00 a.m. tomorrow.

[Whereupon, at 5:19 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, January 15, 2010.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 15, 2010
9:01 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A.
RONALD D. CASTELLANOS, M.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Before we start, I wanted to juggle the schedule a bit. We're scheduled to finish at 12:45, which is too late for me and I know for some other Commissioners, as well, who have to catch airplanes, and so what I propose to do is take 15 minutes off the time for each session, which would have us finishing at noon. So if the presenters can help us out and do their presentations as concisely as possible, then we'll also manage the conversation, as well, to stay within that budget.

So, who's leading? Anne, are you leading?

MS. MUTTI: In this presentation, we consider whether the efficacy of Medicare's quality infrastructure could be improved to advance the goals of high quality and efficiency in care.

While changing payment incentives is key to inducing change and has been much the focus of the Commission's work, Medicare has at least a couple of other levers as part of its quality infrastructure that are also intended to further these goals. They include the provision of technical assistance, which is currently offered through the Quality Improvement Organizations, QIOs, and Conditions

of Participation, which are the minimum, mostly structural, requirements that most providers have to meet in order to participate in Medicare.

We talked about technical assistance at the November meeting and raised several design questions, including what type of assistance is needed, who should the assistance be targeted to, and who should be providing the assistance. In this presentation, we're coming back to the second of these questions, that is, who should the assistance be targeted to, and we're going to explore the degree of variation in the quality of care and the implications of targeting assistance to low performers, and in particular the effect that would have on addressing racial and socio-economic disparities.

The second part of this presentation will focus on Conditions of Participation and explore some possible policy options for strengthening them.

Throughout the presentation, we are using hospitals as an example, but we do this just to simplify and focus our discussion. We are interested in other providers and would be perfectly happy to explore that further in the future.

MR. RICHARDSON: At the risk of stating the obvious, the first point we want to make is that the quality of care varies across the providers serving Medicare beneficiaries. This chart shows just two examples of that variation in the form of two outcome measures, risk-adjusted 30-day all-cause readmission and mortality rates for Medicare patients admitted to inpatient hospitals for a heart attack between July 2005 and June 2008. The data are from the most recent available update of the Medicare Hospital Compare website.

Each graph shows the range between the highest- and lowest-performing hospital and the simple average for each of the rates. As you can see, there is about a ten percentage point difference between the highest and lowest performers on the readmission rate and an almost 15 percentage point spread on the mortality rate.

The spreads for the risk-adjusted heart failure and pneumonia readmission mortality rates that are reported on Hospital Compare are not shown here, are similar.

It is also worth noting that even the best performer on the readmission rate measure still has a rate of about 15 percent. Our point here is not to suggest that

the low end of these ranges is necessarily the ideal performance benchmark for these measures, rather, simply to present a typical example of the range of variation of quality across providers, in this case, hospitals.

Our basic premise for this discussion is that when assessing the quality of care delivered by providers, Medicare should use a single set of risk-adjusted performance benchmarks for all of the providers being measured. An alternative approach would be to use a lower benchmark for providers that start with lower performance scores as a way to lessen the likelihood that, in the case of a readmission penalty policy, they would be financially penalized.

As I will discuss in a moment, our review of the literature on disparities and the quality of care for Medicare beneficiaries suggests that lower-quality performers tend to be providers who care for relatively high proportions of Medicare patients who are minorities and from lower socio-economic status. Thus, one disadvantage of a policy design setting lower performance benchmarks for initially low performers is that it, in essence, would endorse a lower standard of care for a sizeable portion of

poor and minority patients and could perpetuate care disparities. Instead, we start with the premise of a single performance standard for all providers.

And based on your discussion in November about how Medicare might improve its quality improvement infrastructure, we are honing in on the idea of targeting technical assistance to low performers and other providers facing challenges to increase the pace of their quality improvement and to reduce the performance gap between high and low performers.

As I noted a moment ago, research in the literature indicates that white and minority Medicare beneficiaries often receive health care services from different groups of providers and that the quality of care associated with providers used predominately by minorities and lower-income patients is worse. In terms of differences between whites and minorities and sources of care, this research has found that medical care for African American and Hispanic Medicare beneficiaries is concentrated among about 20 to 25 percent of the nation's physicians and hospitals.

These studies also evaluated the quality of care

by the providers serving predominately minority and low-income patients, and the overall findings are that these providers tend to have lower scores on process of care quality measures in the case of the hospital studies and on survey results of provider self-assessments of their ability to provide high-quality care to all of their patients in the case of physician studies. Therefore, it seems logical that targeting technical assistance to increase the quality of all low performers may also have the effect of reducing quality disparities.

The research we reviewed also points out the structural and financial barriers that some low-income providers may face. But we also found evidence from one experiment, where the combination of financial incentives, public reporting of results, and targeted technical assistance to initially low performers appeared to bring about dramatic changes without lowering performance standards for any of the participating providers.

This recent study by Dr. Ashish Jha at Harvard compared the change in quality scores for heart attack, heart failure, and pneumonia care in the set of hospitals participating in the CMS Premier Hospital Quality Incentive

Demonstration. After sorting the hospitals into quartiles based on a CMS index of the hospitals' relative share of low-income patients, Jha found that the hospitals that had the highest fractions of low-income patients also had the lowest quality scores at the start of the demonstration, but that these low performers were able to improve their performance over a four-year period to the point where this group of hospitals achieved the same performance level as the hospitals with the lowest shares of low-income patients that initially had significantly higher performance.

The chart on this slide shows the study's results for the heart attack process of care quality measures. The author found similar results for changes in quality measures for heart failure and pneumonia care.

We note that this study involved a group of hospitals that share characteristics that could limit the generalizability of the results. All of the participating hospitals were members of the Premier Organization, and all were motivated to volunteer to participate in the publicly-reported Medicare Hospital Quality Improvement Demonstration. The study also did not control for possible differences in the secular trends in quality improvement

between the different groups of hospitals. And we also noted in your mailing materials that a few studies by other authors have found smaller increases in quality scores for hospitals serving a high proportion of low-income patients when they examined changes over a similar time period, looking at measures reported on Hospital Compare. However, unlike in the Premier demonstration, those hospitals did not face any financial incentives to improve quality.

Nonetheless, we think that results of Jha's work suggests that hospitals serving a relatively high proportion of low-income patients can respond effectively to quality improvement expectations and incentives. It may be that one critical success factor is the kind of targeted quality improvement technical assistance that was provided by Premier to the initial low-performing hospitals.

Two examples of this technical assistance include provision of centralized data analysis infrastructure and ongoing technical support to increase the timeliness in targeting of internal performance tracking reports for the participating hospitals and the participation by quality improvement experts from Premier in meetings of collaborative work groups with the hospitals to identify

challenges and solutions to meeting the performance standards.

MS. NEPRASH: Since the November meeting, we have examined the correlation between hospitals with high risk-adjusted readmission rates and hospitals with large minority populations. If there is overlap between these populations, as the literature that John mentioned would suggest, a policy of directing technical assistance towards low performers to reduce their readmission rates could have the effect of simultaneously targeting facilities that serve large minority populations.

For this analysis, we made a comparison of hospitals with the highest readmission rates to hospitals with lower readmission rates, examining their racial and socio-economic patient mix. We identified roughly 400 hospitals in the highest quintile of risk-adjusted readmission rates for 2005 through 2007 and compared them to hospitals in the remaining four quintiles. We then calculated the percentage of white and minority Medicare admissions using 2007 MedPAR data. As a proxy for the socio-economic status, we used the Medicare DSH percentage. There is no accepted source of national hospital-level data

on the socio-economic status of patients, but this measure has been used as a proxy in previous analyses.

We found that hospitals with the highest risk-adjusted readmission rates had a different racial and ethnic patient mix than their lower readmission rate counterparts. In 2007, they admitted a significantly greater percentage of minority Medicare beneficiaries. On average, minorities represented 30 percent of all admissions at these high readmission hospitals, compared with roughly 15 percent of all admissions at hospitals with lower readmission rates. Hospitals with the highest readmission rates also had, on average, a higher DSH population, suggesting that they may be serving a lower-income population than other hospitals.

So this analysis of patient characteristics at hospitals with the highest readmission rates indicates that a possible policy of directing technical assistance towards low performers to reduce their readmission rates could have the effect of simultaneously targeting facilities that serve large minority and socio-economically disadvantaged populations.

MS. MUTTI: So now we will switch gears and explore COPs to ask if they and the survey process that

enforces them can be better leveraged to improve quality of care.

Conditions of Participation are tailored to each applicable provider type, so the COPs apply to hospitals, home health agencies, SNFs, and some other 15 categories of provider types. They do not apply to physicians. Today, I'll mainly talk about COPs as they apply to hospitals, but as I said, we could consider it more broadly in the future.

The COPs mainly require that certain structural and physical and management structures are in place. For example, requirements for hospitals apply to such areas as the governing body, patients' rights, the medical staff, nursing services, radiology services, discharge planning, and infection control, but there are many other categories. They have been updated somewhat over time. Most notably, the quality requirements have been expanded to require that hospitals systematically measure their quality performance in certain areas of their choosing and implement specific improvement projects.

The COPs for transplant services reflect a somewhat different approach to COPs, one that is more proactive in ensuring quality. In addition to the

requirements that other hospital units have in terms of providing information about patient rights, doing quality improvement, transplant centers also have requirements on their clinical experience and patient outcomes. So, for example, lung, heart, and liver transplant centers have a requirement that they perform an average of ten transplants per year and they also have to have acceptable survival rates in order to be approved.

Providers must be surveyed periodically to demonstrate that they are in compliance with the Conditions of Participation. Hospitals may either be surveyed by private accreditors, mainly the Joint Commission, or State agencies, and most are accredited. Both types of entities conduct unannounced surveys, and in their surveys, they both use the "tracer methodology," which means that in addition to reviewing records and minutes from meetings and interviewing staff, they also identify a sample of patients currently hospitalized and examine the processes of care as they affected the care of these selected patients, and they have the opportunity to interview these patients and their families, as well.

Accreditation differs from surveys by State

agencies in that they tend to be more frequent, charge for their services, and require compliance with national patient safety goals, and these goals include things like making sure you are identifying the right body part that surgery is going to be performed on, you have handwashing to prevent infections, maybe better communication techniques between staff. If a facility fails the accreditation or the State survey process, it is precluded from participating in Medicare, but this happens very rarely. I'm still searching for statistics on that, but it's very rare.

There is mixed evidence on the efficacy of the accreditation process. Some studies suggest accredited hospitals perform better on certain quality metrics and others do not. There seems to be the sense, though, that the changes in the accreditation process in recent years, the ones I mentioned about the tracer methodology, the national patient safety goals, unannounced surveys, have all been very positive changes. But there are concerns still about the ability of accreditors or State surveyors, for that matter, to drive improvements on some more nuanced areas, like medication reconciliation or encouraging a culture of patient safety.

In any case, the fact that there is wide variation in quality and that there's a fairly high rate of success among those seeking accreditation -- most get it -- suggests that the accreditation process is more of an inclusive one that ideally allows for an education process between the surveyors and the hospitals and also allows opportunity for a correction in deficiencies. It's not especially punitive in that sense.

So with that background and given the general concern that progress on quality has been frustratingly slow, we wanted to consider options that might drive faster improvements. And the options here that we're going to talk about are very broadly sped-ed out and really intended to stimulate our thinking and to help us ask the right questions, because we recognize that we are very much at the beginning of this process and coming up on our learning curve on this issue.

So the options I'll present are not necessarily alternatives to one another, so you might want to think of them -- some of them could be combined with others, but this is very much for discussion. I'll briefly summarize the ones I'm going to talk about.

First, we'll talk about an option to make the survey findings more transparent.

The next two will consider whether the current COPs should be updated to reflect new evidence on what factors can improve quality of care and to introduce the idea of efficiency as something that could be included in the COPs.

Then there's an option to create an optional set of higher standards that can earn providers distinction among their peers, and these standards could move beyond more of the structural requirements and get into maybe more outcomes-oriented standards.

And lastly, we consider a couple variations on an option that would create mandatory higher standards for select services or organizations.

So the first option, again, is to make the survey findings more transparent to consumers and other providers, creating more motivation for providers to perform well on surveys, and it could follow the precedent established by CMS in providing information about nursing home quality. As part of the Five-Star Quality Rating System for nursing homes, CMS now provides three types of information about

each nursing home on its website: Details of survey findings, nursing staffing levels, and performance on quality measures.

In contrast, the findings on hospital surveys are not publicly available. Only the ultimate accreditation status is available, and this may be of minimal use to consumers since the vast majority of hospitals receive the same accreditation status.

The disadvantages of greater transparency are that consumers may be already overwhelmed by information, and also the survey results may be more complicated to explain for hospitals than for nursing homes. The range of services provided is far more diverse.

Another option is to update the COPs to update newer research about what dynamics lead to improved quality. For example, here, the COPs could be strengthened to improve the discharge process. For example, the COPs could require that hospital staff go over a discharge checklist with patients to increase the likelihood that patients know how to care for themselves at discharge and decrease the chances that they'll be readmitted. CMS has already developed such a checklist.

The COPs could also require that a list of medications be provided at discharge and require that follow-up appointments be arranged prior to discharge, two things that research tells us could reduce readmissions. These types of requirements would be in addition to some existing ones that require a hospital to do such things as prepare patients for post-hospital care and supply lists of local PAC providers.

Another area that might be ripe for more specific requirements concerns the role of the board of directors and its potential to drive culture change around quality. A recent study found that 66 percent of hospital boards thought their quality scores were better or much better than the typical U.S. hospital, and most notably, none of the boards of low-performing hospitals thought their quality was worse than the typical hospital. Indeed, 58 percent of them reported their performance to be better or much better. So while COPs require the board to be involved in quality improvement, obviously, the requirement is not reliably leading to meaningful engagement, so one solution may be for the COPs to be more specific and binding in that area.

A disadvantage of these types of changes is that

they're prescriptive and as such may hamper innovation or not allow for reasonable exceptions. Also, CMS has limited resources, so promulgating regulations to update them frequently is resource-consuming.

Another policy option is to expand the COPs to require efficiency-enhancing activities. Currently, the COPs require the hospitals to perform those quality improvement activities, and this would be a parallel type of requirement that we could consider. The activities would not necessarily be prescriptive, just like with the quality requirements. It's at the hospital's choice. But they must be able to be validated by surveyors.

The Institute of Healthcare Improvement, IHI, has shown that there are efficiency opportunities and has launched its own program on improving efficiency and reducing waste. IHI's vision of waste reduction calls for organizations to set waste reduction targets, like one to three percent of operating expense, and then IHI goes on to offer examples of how improvements in staffing -- in that respect, it's lower turnover, higher productivity, safer care -- can lead to greater efficiency. They also identify areas like patient flow, the supply chain, and reduction in

mismatched services, and here one of the examples is offering palliative care in the ICU setting. They identify pioneers out there in the field that are using these strategies and achieving their objectives.

Another option is to create a more rigorous set of optional COPs to allow providers the opportunity to demonstrate their higher quality and publicly distinguish themselves with a single designation, like a platinum award versus a gold award or something like that. These standards could be based on outcomes measures, adherence to evidence-based practices that are more likely to correlate with higher quality care than current standards, or implementation of practices consistent with a culture of patient safety. If providers found the designation valuable, more may be inclined to meet this higher standard of care. The current set of COPs could continue to apply to providers not opting or achieving for this higher standard.

There are several disadvantages to this option. First, providers may have little incentive to meet the new standards if there's no payment incentive. They may feel they can already demonstrate higher quality through some of the data that we're making public as well as other

accreditation or certification programs from the Joint Commission or NCQA. And also, it's possible that pay-for-performance would accomplish much of the same objective more effectively, so that's something to consider.

On the other hand, it is possible that having two levels of COP designation may have the advantage of simplifying the message to consumers and further motivate providers. In addition, redundancy in public policy may not be a bad thing, and some of the things that we might have in a higher set of COPs may not be captured in a P4P measure set.

Our last option here is to create mandatory higher standards for select services or organizations, and here, we present two variations of the option on one slide. One option would be to amend the COPs to incorporate outcomes or volume criteria for select services, and this would be much like how we do it for transplant centers, those same type of requirements. So we would restrict payment for certain services to providers that demonstrate sufficient volume and quality, and this is similar also to the Centers of Excellence concept, and it would give our beneficiaries -- and help guide our beneficiaries to providers with best

outcomes.

The possible disadvantages to this option are that it requires consensus about the evidence governing the criteria. Beneficiaries might have to travel further to get their care. And such restrictions create barriers to entry for new providers and could hamper a competitive marketplace.

A variation would be to create higher standards for certain types of integrated organizations. For example, as providers come together to form ACOs or other types of integrated organizations, they may have -- they should have more control over the spectrum of care. Accordingly, higher standards, especially concerning care management across settings and health promotion in the community could be expected.

They could go further. David Cutler posits that hospital systems that account for a quarter of the market must do more to manage the care of their patients who come through their doors. He suggests these big systems must guarantee an adequate supply of primary care everywhere in the community and ensure appropriate access to emergency services.

Higher standards might be a helpful check in ensuring that consumers were getting greater value, particularly if a byproduct of ACOs was the ability to gain more negotiating leverage with private insurers for higher payments.

Among the possible disadvantages to this option is the prescriptive nature of mandatory requirements and also that the payment incentives that are part of the ACO concept may be sufficient to engender the desired attentiveness to cost and quality and that a regulatory overlay would not be necessary.

So to close, we are interested in all of your comments, of course, but especially on these two topics: Targeting technical assistance resources to low performers and providers with challenges. Depending on your discussion, we could bring you a draft recommendation as well as a more comprehensive discussion of the pros and cons of such a recommendation.

Also, with respect to policy options for strengthening Conditions of Participation, we would welcome your insight into ones we should be dropping off our list or ones that we should add on. We recognize that we are very

much at the outset of our thought on this.

MR. HACKBARTH: Okay. Thank you.

So this is our second discussion of this broad area. You'll recall we had a presentation in November, I believe it was. And, in essence, I think we've opened a lot of different doors that we could choose to go through, and my objective for today's conversation is to figure out which, if any, of the doors we might go through. I'm trying to organize my own thoughts about the possibilities. It seems to me that we've got a disparate set of possibilities on the table. Here are some thoughts that come to my mind.

A relatively narrow -- and I use "relatively" with some intention -- approach to this would be to say, look, we know that it's quite likely that there will be movement on readmissions and maybe infection rates and there will be pressure applied to hospitals in those particular areas, maybe coupled with payment incentives through the health reform legislation. And so the focus could be narrowly on that and what sort of support should Medicare be providing to institutions perhaps with a particular focus on institutions that are currently low performers and may have disproportionate numbers of low-income and minorities. So

that would be one type of relatively narrow focus.

A somewhat broader approach would be to tackle the issues of disparities more broadly and say that that's a problem for the program and that we want to assess options for addressing that.

Still another approach would be to say -- now this is about the QIO program in particular. We have been spending, you know, hundreds of millions of dollars for a long period of time. We need to examine whether that has been a productive investment, how it might be restructured to make that investment more effective.

Still another door is the whole COP thing, which seems to me to have some very different characteristics from the three previous approaches.

I don't offer these as the only potential paths, but these are just different planes on which you can attack this that quickly come to my mind.

So what I'd like to accomplish during our discussion is to get input from you on whether you think we ought to take one of these approaches or whether you sort of cut the issue differently. But I think now having devoted, at the end of this, two sessions on this, it's time for us

to really start to hone in on what we think the opportunity might be in this broad area.

Does that make sense to you folks? Mark, do you have anything on that? Jay?

[No response.]

MR. HACKBARTH: So we'll begin with our usual round one, focused simply on clarifying questions about the presentation, and then in round two I would hope we could get your input on the issues that I've raised. So let me see hands for round one clarifying questions.

DR. DEAN: Did you look into how these ideas would blend with what CMS is already doing on value-based purchasing and how that -- I'm not exactly sure where that stands. I was involved in some of the discussions early on about the structure of that, and I know it's moving ahead, but I don't know where it stands. But it certainly addresses some of these same issues, and whatever we'd recommend should be in concert with that.

MS. MUTTI: Right. At least that's one reason why I mentioned that we do have to ask ourselves whether these things fit together or whether some of the value-based purchasing achieves our objectives and we don't need to go

into the conditions of participation because we're going to go in through a different door and get them through P4P. So certainly one of the questions we had was understanding -- that we need to understand a little better how it would either complement it or it's redundant.

DR. DEAN: Maybe Herb knows the answer, but that is moving ahead, isn't it? I mean, it's going to happen, I think.

MS. MUTTI: Yeah, John can speak to that, too.

MR. RICHARDSON: Yeah, the pending Senate bill, which now they're, of course, merging together with the House bill, did include a form of hospital value-based purchasing proposal, and I believe, as Anne said, you know, some of the things that we're talking about here could -- for example, targeting technical assistance to low performers in there would presumably affect the way that those hospitals did on that program if it actually was enacted.

DR. DEAN: I thought it was actually moving ahead even before the reform proposal.

MR. RICHARDSON: CMS made a proposal, but it cannot be implemented unless they have legislative

authority.

DR. DEAN: I see. Okay. The one issue that came up a lot in the discussions early on was that if you only reward the people that achieve a certain level, it's the same people and you'll just -- the people that are doing well will continue to do well, and the others won't; that you need to reward both improvement and achievement, which makes the formula pretty complicated.

MR. RICHARDSON: And that has been the Commission's position since 2005 very explicitly.

MR. HACKBARTH: Right, both achievement and improvement.

MR. RICHARDSON: And that is in the legislative proposal, too. Excuse me. That's also in the legislative proposal.

DR. MARK MILLER: Just to say two things quickly about that exchange. I think some of the thinking here is you have value-based purchasing or pay-for-performance or whatever label you use to it. Then part of this discussion has been how do we help potentially low performers actually get into that game. That's part of the discussion. And then the COP discussion, the way I've always seen it, which

hopefully is not a complete surprise to you guys, is there is sort of a two-step process. If you're getting quality to improve, what you'd like to do is use the COPs to say, okay, now I've got a new minimum standard, and you sort of move, you know, up and kind of use the COPs to institutionalize or lock those changes in place.

MR. KUHN: Just before I ask my question, one observation about what Tom asked on that issue is that you raise the issue of the Premier demonstration, and it's a tournament model -- that is, there's winners and losers, what you referenced, Tom. And then when MedPAC opined on this issue, they said we really don't think a tournament model makes the best sense because you widen the gap between the winners and losers, and we ought to reward people for performance who've attained as well as improvement.

CMS, when they did their report to Congress on their strategic plan, at least for hospital value-based purchasing when they issued that two years ago last November, followed that same framework -- that is, improvement and attainment -- and got away from the tournament model. But, regrettably, to a degree what we're seeing in some of the legislation now is going back to the

tournament model, and part of that is because it scores. I mean, in order to get scoring, you have to -- if you're going to reward some people, you have to penalize others in order to take money back. And so that's the dilemma that we face, kind of going into this just so people understand kind of where that is.

Having said that, the one question I had on the COPs is that the COPs, when they're put together or developed, they are put out for public comment, notice and comment. Correct?

MS. MUTTI: Yes.

MR. KUHN: And then also, then following the COPS are the interpretive guidelines which may help the surveyors and everyone work through those, and those are not put out for public comment. Is that correct?

MS. MUTTI: No. As I understand it, it makes it a much easier process for CMS to update as a result.

MR. KUHN: To do. And then, finally, for a lot of the quality -- as you indicated, a lot of the quality COPs that CMS has put together, how are they doing in terms of writing the interpretive guidelines? I understand they're kind of behind on some of those and they don't have a

complete set of interpretive guidelines to go with the COPs. Is that correct, or --

MS. MUTTI: Yeah, I don't know about that, and I would be happy to look into that for you.

MR. KUHN: Okay. Thank you.

MR. GEORGE MILLER: Yes. First of all, thank you. Very, very good work. I've got a couple of questions. I'll narrow them down to the technical questions.

On page 12, in the reading, you have a table talking about Medicare admissions unique beneficiaries by race and ethnicity. Do you propose that this should be used and make this part of a by race readmission criteria? Is that what you're suggesting that should be done? I've never seen this before, so my question is: Is this something that you're suggesting should be part of the literature going forward?

MS. NEPRASH: This table is just part of the analysis of --

MR. GEORGE MILLER: Yeah, I got as far as analysis. This is good information. But what I'm asking is: Are you going to make this a recommendation to be included for all hospitals?

DR. MARK MILLER: I think if I understand the question [off microphone] -- sorry.

MR. GEORGE MILLER: I'm trying to get --

DR. MARK MILLER: Yeah, I hear you, and I think if I understand your question, the question on the table to the Commission is -- and this in some ways could be linked up to what Glenn was saying as well. Let's say that one of the ways that we're going to pursue this issue is to have a hard focus on the readmission policy. You know, the Commission recommended this strategy. The Hill is clearly picking it up and pursuing it.

Now, the thing about the readmission policy is that some people have said the concern there is because there's a penalty. Marginal hospitals, hospitals without a lot of resources, and potentially poor-performing hospitals are going to not be able to, you know, improve and are going to be hit by the penalty, and that will make it even harder to perform.

So one question for the Commission -- in some ways I think why they're balking is this is a question for all of us, all of you guys, really -- is one strategy to say, okay, let's take some resources, let's pretend for a minute the

QIO resources, and redirect them in such a way that there's some short-term support for those types of hospitals, short term in the sense for any individual hospital but an ongoing process, to allow them to bring their performance up so that their readmission rates are not as high as they are and they aren't hit by the penalty. This is not for every hospital, but focusing in on certain hospitals.

The connection to, I think, the table you're talking about is, by the way, this turns out to be hospitals that see disproportionately large numbers of minorities, might have the secondary impact or, you know, complementary impact of improving care for those, those populations.

Does that answer your question? Or are you on a completely different angle here?

MR. GEORGE MILLER: Well, it does to probably about 90 percent. Obviously, the goal, at least in my mind -- let me rephrase that -- is to improve disparities across the spectrum, and this certainly illuminates a readmission threshold -- not threshold, but it identifies a segment's readmission issues for both minorities and -- I'm not sure if it also addresses socioeconomic here, but it does differentiate minorities. For example, I said before I am

just as concerned about Appalachian whites getting the same level of care as anyone else.

So the question, at least in my mind, is: Will this help by identifying and make this a requirement -- is this one of the steps that we could use to increase quality and eliminate disparities? I don't know the mechanism, but that's the question.

MR. HACKBARTH: In that sentence, the "this" -- what is the "this" that you're referring to?

MR. GEORGE MILLER: Making it a requirement that readmission rates be done by minorities and socioeconomic status.

MR. HACKBARTH: Reporting?

DR. MARK MILLER: Just reporting?

MR. GEORGE MILLER: Reporting, yes.

DR. MARK MILLER: Oh, I see. Again, I think that's a question for us, but it certainly is something that can be done and can be reported. Sorry. Can be done, can be reported, for the record.

MR. GEORGE MILLER: Highlight and put a focus on that issue by putting this information out in the public domain.

DR. MARK MILLER: Absolutely.

MR. BERTKO: Two follow-up questions. The first is on page 18, when you talk about a voluntary higher standard, this sounds like a potentially good idea. Are there any examples of that out there today? Or is this just theoretical?

MS. MUTTI: I know that NCQA has in the past experimented -- has used voluntary higher standards, but I don't have the specific examples for you, but I can get that.

MR. BERTKO: Okay.

MS. MUTTI: That they have found it to be a useful way of, one, testing some new ideas and then it also can allow them over time to bring up their standards, give people kind of the heads up that's the direction they're moving and they get some progress on that.

MR. BERTKO: Okay. The second question refers to something you guys have prompted me to think about on accountable care organizations with the COP. I'll again identify myself as being with the Dartmouth-Brookings ACO team. We have constantly said we want to have some set of quality standards to start with. It sounds like here -- I

haven't thought about this in terms of a COP, but it sounds like a perfectly good way to fit this in here with an ACO being subject to COPs. I would think that, you know, if MedPAC wants to come in and say follow these standards to serve as that quality step, I think that would be good. And I'd also make the point, I think, Mark, kind of following on your lines, start with something that many or most could do and have it evolve step by step with an intentional path towards higher standards over time. So maybe we can put some work into that.

DR. BERENSON: This is very interesting material. I want to follow up on the characteristics of hospitals with high readmission rates. Some hospitals make the argument that they can't control readmission rates, that once the patient walks out the door, there's this ambulatory care system that sort of takes over. And I'm not terribly sympathetic to that argument, but I do wonder about particular hospitals where they might be in areas with just very underdeveloped ambulatory care sectors, that there's no one to collaborate with.

Do we have any -- can we or do we know anything about sort of the ambulatory care structure in the areas for

these hospitals that we've identified? And one specific question I would have, the data from readmission rates that show the percentage of patients who had an outpatient visit before they were readmitted, and I guess overall only about half of the people -- I mean, do we see differentials there?

I guess what I'm asking, do we know anything now and can we flesh out a little bit to sort of see to what extent we really can hold these hospitals wholly accountable for their readmission rates? And to what extent do we have to acknowledge that they are in underdeveloped -- they have an infrastructure around them that is different from what most other hospitals have?

MS. NEPRASH: I think that's an excellent point, and the answer right now is that we have not looked at the community around these hospitals in terms of access to ambulatory care. But I will look into the percentage that had an outpatient visit before the readmission and get back to you on that, and if you think of others, feel free to discuss.

MR. HACKBARTH: Bob's comment raises in my mind still another way that you might choose to look at this issue. So, you know, one approach would be to focus on

particular problems like readmissions or infection rates. A different plane on which to cut it is to say Medicare ought to be focusing its support, resources, on problems that cut across institutional lines where the infrastructure may not exist, the mechanisms may not exist to deal with a problem like readmissions to the extent that it involves, you know, poor community support on ambulatory care. And without integrated systems, providers will need some focused help to sort of knit together to deal with challenges like that. So that's still another way that this could be cut.

DR. MILSTEIN: Anne, a couple questions. Could you elaborate a little bit more on the chapter? Because I think your notion of building on precedent is a terrific idea as, you know, referenced in your chapter saying in some ways Medicare has already moved in this direction through, you know, how it handles transplant centers. Not all hospitals can participate in the Medicare program with respect to major organ transplants. But I wasn't sure how to interpret -- I have two questions. The first is I didn't know how to interpret these words, if a transplant center fails certain outcome tests, CMS will "not consider survival rates acceptable." Then what happens?

MS. MUTTI: As I understand, then that transplant center loses its approval, ability to continue to perform.

DR. MILSTEIN: So that if you're no longer participating, what I'll call sort of a high-risk segment of the Medicare -- okay, that's --

MS. MUTTI: And I did read recently that there has been precedent for that, that they found that the center was not meeting its standards and it no longer provides those services.

DR. MILSTEIN: Terrific.

MS. MUTTI: So it has been enforced.

DR. MILSTEIN: That's an editorial comment, not round one, but it's a nice precedent to build on because it's already established.

The second question I have, Anne, you know, as an aside, one of the things that I've done outside of my MedPAC life is, you know, supervise a unit that it gets called in when a hospital is under threat of losing Medicare participation. I've been doing this for about 25 years. And I will say that it's just breathtaking to sort of see what happens, you know, when a death sentence is on a hospital. I mean, the speed and rate of transformation and

change in management structure and investment just, you know, turns around overnight, very analogous to a death row conversion.

[Laughter.]

DR. MILSTEIN: My question is: Do you think it might be possible as part of our research to kind of, you know, look into the history there of what happens in hospitals where they sort of, you know, catch on fire with respect to -- in other words, meaning in some -- they become actually visibly frightened they're going to lose their ability to participate in the Medicare program? And what can be gleaned maybe from, you know, discussions with the OIG and others that, you know, tend to get involved at that point? Because it's a wonderful potential source of information on how to take a very bad performer and move its performance dramatically. And there may be some lessons we might extract.

MS. MUTTI: Definitely.

MR. HACKBARTH: Other round one questions?

DR. STUART: Both Glenn and Mark raised the issue of the QIO, and so my question is broadly focused on the extent to which you've talked to CMS about QIO activities in

this area, because the Eighth Scope of Work does include some very specific projects related to targeting technical assistance, including one that I'll have to say I consider really extreme, but you might be able to learn something from it. It's called the Nursing Home in Need Program where every QIO is supposed to identify three really bad nursing home providers in its region and then spend a whole year with each one of them.

Mathematica has been tasked to do an evaluation, kind of an assessment of both what the QIOs are doing, how others outside of the QIOs think about what they're doing, to help the agency develop the next scope of work. So that's something that you might -- if you haven't already, you might follow up with CMS in terms of what Mathematic is involved in.

MS. MUTTI: And that is a really good point. We mentioned it last time, but we didn't mention it in this presentation, that the targeting is quite consistent with the direction that CMS is moving in, so it would be a bit of a reiteration of that.

DR. STUART: I was involved in a listening session -- CMS was doing the listening -- where there were various

individuals that were asked to comment on this, and the comments around the table were, I guess, very much in terms of what we have around the table here in terms of real questions about what do you get when you target at the low end and do you just lower your expectations when you do that, and then how you take this information and actually, you know, bring all ships up. So there is some additional information, I think, to be had, whether it's available right now or not, but it's something that should be available fairly soon.

MS. MUTTI: Okay. Great.

MR. BUTLER: So my research by anecdote, which I'm not sure my numbers are right, but my bias would be -- and I'm going to get to a Premier question here -- that there are a series of -- these low performers on readmission and outcome, also on mortality, have other things in common. They don't do very well on the HCAHPs in terms of patient satisfaction. They're kind of nowhere on the IT development. They have high Medicare-Medicaid percentage. And there are a lot of these that are sitting in urban markets. And they're freestanding; they're not part of a system. At least there are a series of institutions like

that, and they're very much needed in the local communities.

So one side of it says, well, there are corner drug stores, and they're a model that just is not going to survive regardless. But we need a lifeline because the care is needed in those communities. That's kind of how I see this.

So my question related to this is, in the Premier, if you had these low performers that suddenly came up dramatically compared to others -- it's the first time I've kind of seen that -- were these -- because Premier has a lot of systems in there. Were these hospitals that were part of a system? Or can we also point to the participants in the Premier study who were freestanding and were able to achieve those kind of results without the support of a system around them?

MR. RICHARDSON: I don't know the answer to whether they were, say, Catholic Healthcare System or something like that. They were all, obviously, participants in the Premier family, if you want to call it that. They all worked with Premier to some level of either data analysis; they may have been participating in Premier as part of their group purchasing -

MR. BUTLER: I was looking at Herb because he was Mr. Premier at one point in time and may have --

MR. KUHN: You had a great variety of hospitals. You had those that were systems, those that were stand-alone, urban-rural, so a great variety. So some had their own infrastructure support. Some worked with the QIOs to develop those networks within their communities to put things together. You saw a number of different strategies. But I think the unifying force is that Premier itself created some collaboratives among all the institutions to help, kind of lift all boats as part of the process.

So individual markets vary differently, but there was this one kind of unifying thing that Premier itself put together to help them.

DR. MARK MILLER: What I was recalling is I thought we had a conversation. We talked about this a little bit, and we thought, you know, Premier was a good -- there were lots of good things to come out of it. But we were wondering whether that was generalizable given the fact that they voluntarily did it. There was something, even if it was an individual hospital, there was something of kind of a system around this effort. And so I think your

question is sort of, well, what about a true stand-alone, I'm out here on my own. And I thought we had some questions about how generalizable that was because there seemed to be some infrastructure there, and in a sense, the implicit conversation we're having here is, well, should Medicare be providing some of that infrastructure for people who don't have it? Is that a fair characterization of the conversation?

MR. GEORGE MILLER: Yeah. And on that point, Peter brought a good question that I had in my notes to ask maybe in round two, and that is the IS question. Do these institutions have the same or credible inform systems to give them the data they need to make their improvements? Or is that something Premier provided for them? Do we know that information? Because the data collection would be critically important.

MR. RICHARDSON: What I've read so far is that it was a combination of both the hospitals themselves had some capabilities and then Premier gave them tools that allowed them to not only improve their own data infrastructure, but then share information across all the hospitals participating. But, Peter, I interpreted your question to

mean did the hospitals that had the higher percentage of minority or low-income patients, low-income, were they in a system or not, and that's what I don't know and could find out in terms of the graph I showed, the ones that had the higher proportion of low-income patients and what their characteristics were relative to --

MR. BUTLER: No, I was really just looking for the -- I think that may be a characteristic of the low performers, as you've already demonstrated in general in your data. It may not have been true in the Premier study. But I was really looking to see if they were really trying to say have we demonstrated that a freestanding institution given support can lift itself, or do they, in fact, ultimately have to be part of a system to get kind of the infrastructure that will really sustain themselves over time? It's a very different answer if we have the government play that role versus, say -- you know, the facts are we should encourage the development of these systems. In fact, maybe in the major metropolitan areas, you know, find ways to incentivize, or whatever, the bigger systems not to abandon those that are closing but, in fact, find ways to create community-wide looks at access in a way that

we really have not -- that the market by itself doesn't do.

MR. HACKBARTH: Okay, Jennie has the last clarifying question. Then we need to get to round two. We've got 20 minutes left, and I want to be able to give as many people who want to weigh in on how to focus this effort in the future the opportunity to do so.

MS. HANSEN: Yeah, this is a question for the topic of governance that you brought up for boards of directors. Was there any evidence to show that -- one, was the study about how people self-perceived their quality versus people who -- governance structures that were required to sign off on the quality? In other words, the fact that getting kind of passively reports of quality but to take some ownership, were there any studies to show any systems, whether it's Premier or others, that actually had to sign off on the fact that they read these studies, understood the implications?

MS. MUTTI: Right. The study that we cited did not ask that question. It did, you know, using Hospital Compare or other data, you know, we know this is their performance, and then we asked the boards, you know, what is your -- how would you answer these questions and compared it

and showed that they didn't line up.

We offer that possibility in the paper. How do we get the bindingness? Do you need to require them to sign physically that "I have read this is what my hospital performance is"? It is a very, you know, off-the-cuff kind of answer that we certainly would want to vet with other people to see if that's it. But that's the kind of notion we were thinking of. I don't know what other -- you know, a Premier initiative or HCA or some of these other systems that have put together quality improvement programs, exactly how they've engaged their boards.

MS. HANSEN: You know, with the Sarbanes-Oxley, other requirements, some governance kind of requirements to have some accountability, it causes people to pay attention.

MS. MUTTI: Yeah, and I cited this in the paper, too, but both NQF and also the HHS-OIG have put out papers in the last five years or so calling for greater board involvement, showing concern that there hasn't been enough.

MR. HACKBARTH: Okay. I'm going to ask Jay to kick off round two.

DR. CROSSON: Well, let me just first say I'm not sure what's going to come out, because I'm quite caffeine-

sensitive, and somebody must have switched the decaf and the regular coffee, and I feel like my head is just going to blow up.

[Laughter.]

DR. MARK MILLER: There is a lot of drama here.

DR. CROSSON: So I have one specific comment and a couple of general ones.

Just with respect to the conditions of participation -- and I think on Slide 14, you mention that one approach might be to work with the governing bodies of the hospital -- I would just hope that in that particular line of thought we also include the organized medical staff and the medical executive committee, because I think there's a lot of evidence that most quality improvement in hospitals really requires the active participation of the physician staff. And, in fact, in some states, including California, the physician staff as organized is a semi-autonomous body, and so it's not just purely about the hospital governance per se, no offense to any other Commissioners.

But with respect to the content, you know, after the November discussion about the QIOs, I took a look at some information about one large state and its QIO from the

perspective of how effective it might be, and I'm not going to really comment on that, but what really struck me was the question of how it really could be effective given the amount of resources.

Now, Glenn mentioned that there's hundreds of millions of dollars expended a year across the country, and that's true. But if you look at this one particular large state, the budget is actually $12 million a year for a state that has several hundred hospitals, around 70,000 physicians, and hundreds of home health agencies, SNFs, and the like.

MR. HACKBARTH: What state might that be?

[Laughter.]

DR. CROSSON: It's actually not California. It's not California. I have some thoughts about the process in my own state, but this is another state. There aren't many in that category, I understand.

MR. HACKBARTH: We're narrowing it down [off microphone].

DR. CROSSON: Right, we're narrowing it down. So, you know -- and some 40 employees. So, I mean, as I thought about it and the scope of both the issues of quality and the

issue of efficiency that you've introduced, it just seems to me hard to imagine how an organization of that size could actually do very much.

So I do think that the question of whether or not the QIOs as organized and as funded, whether there would need to be a separate one in every state, for example, or almost every state, for example, whether the mission that they're given, given the amount of money that they have, is actually doable are legitimate questions, and we ought to look at that. And that's not to take anything away from any of the individuals who work in those organizations, but to me the math doesn't compute very well. And so the idea of rethinking it I think is a good one.

With respect to the conditions of participation question, you know, Arnie -- I mean, I agree with Arnie because I've seen that sort of situation before. I worry, though, about whether that endpoint -- that is, loss of participation in Medicare -- is too sharp an endpoint to actually find its way into a systematic process of quality improvement, because it is so catastrophic for communities or for organizations that there's the risk of people backing away from it in the end.

So the choices seem to me either to develop some other endpoint for conditions of participation, and you've suggested some in the presentation. Other organizations like NCQA, for example, have different levels of certification or qualification, whatever you want to call it, as does the Joint Commission, so you could do that. But then you have to say, well, then, but so what impact does that actually have on the business of that entity.

Another choice would be -- and we haven't really brought it into play here -- is the question of expanding pay-for-performance. So as I think about the traditional breakdown of, you know, the three elements, the Donabedian elements of quality -- structure, process, and outcome -- it just seems to me that issues of structure and process fit more with the central tenets of conditions of participation. In other words, if you don't have certain elements of structure and process, then you really can't play in the game, and your job, if you don't have them, is to make sure you do have them; whereas, outcomes, you know, what you're able to produce with what you've got seems to fit more with the concept of gradated reward or punishment by CMS in the area of then expanding the idea of pay-for-performance,

which we've started on, and it's difficult because it's hard to find measures that work really well and the like.

But I think we have a potential to go a lot further with that and that that's better than trying to put, you know, relative performance or performance on outcomes into the conditions of participation framework.

MR. HACKBARTH: Just a quick thought here. So one set of questions is how to motivate change. Another set of questions is how to support change once you have somebody that you assume to be motivated. And, you know, I think it's useful to sort of parse those, and one of the decisions we need to make is are we doing one or the other or both of those questions.

Okay. Let me see other hands for comments. We'll just go down the row here.

DR. DEAN: I'd like to follow up. I especially concur with what Bob was talking about, the whole readmission issue as a measure, but also as you said, Glenn, I think it's a very good measure because it does cut across different parts of the system. It's true that it's not really fair -- I mean, I think hospital people will say it's not really fair to put all that burden on me because a lot

of that I can't control. On the other hand, somebody has to take some responsibility to begin to build the systems that will give us that kind of care, and it really is a measure of quality, I think, better than many of these other more specific things that we use.

There was a very interesting presentation I heard a couple years ago that Dave Durenberger organized with a fellow who was the CEO of Parkland in Dallas, and he talked about how -- he was talking about mostly about emergency room use, but I suspect it would spill over into readmissions -- about how their emergency rooms were just overwhelmed -- and, of course, they're in a difficult situation, different environment -- and how they had specifically taken the responsibility to try to build up the primary care infrastructure in their neighborhood, and, in fact, where most other emergency room use was going up, theirs went down. And he wasn't talking about readmissions, but my guess is that the same would apply to that.

So there are examples of places where they've done this and shown that if an organization takes the responsibility to try to look beyond their walls, they really can improve the outcomes for the people they serve.

And I think that's the direction -- we need to take a broader view of all this and encourage us -- so I guess I'm saying that looking at readmissions I think is a measure that does cut across those areas and something that is important.

What it boils down to so often, I mean, resources are important, your location is important, but the key thing is local leadership, and where you've got local leadership, these things a lot of times happen, even in some very difficult situations. And if you don't have local leadership -- and it's a hard thing to produce, but I think we need to recognize that so much depends on local leadership -- although as Peter said, you know, I think being in a system mitigates some of that.

MR. HACKBARTH: Okay. We have just about ten minutes, a little less than ten minutes to go, so if I could ask people to keep that in mind.

MR. KUHN: Let me be real quick here.

One, let's make sure that we don't oversell the COPs because COPs really focus on minutiae and the fact that a physician doesn't put a time on a particular form means a failure of a COP. So I want to make sure that we try to

strike a balance here in what we put together in this chapter, that we really want people to focus resources and time and efforts on improving quality performance, not chasing hospital staff or other clinicians in order to make sure paperwork is all in order. So we need to find a balance.

Having said that, I do like the discussion we've had this morning about the COPs and the interpretive guidelines in the area of the transplant sector. Remember, this is an area where they were outside the COPs until about three and a half years ago. They were part of a national coverage determination by CMS. CMS did a regulation, brought them into the COPs, and this is one that they had a mulligan, they had a do-over. They could start from scratch on this one. And they got it right, and I think they did a very good job on this, and I think we need to highlight that in a text box, quite frankly, and discuss where this is really one that focuses on quality improvement, volume, outcomes, and I think that's a real good example of starting over.

Likewise, in that same vein, where I think a good example of where COPs could be very effective is in the area

we've talked about as readmissions. Right now, the current COP, if I understand it, on readmissions is that hospitals need to have the readmission work done -- or the discharge stuff within 30 days -- 30 days afterwards. You know, a much more, I think, appropriate COP would be within seven days that summaries go to the physicians and the post-acute-care providers. That makes a lot more sense, and I think this is something, again, an example where a COP is antiquated when you think about where we're trying to drive forward in terms of readmission policies.

And if you take it a step further, we ought to be thinking about that there ought to be HCAHPS measures that focus on this area and that we harmonize across all the areas so that everything is focused on the outcome, that is, to improve readmissions, whether it's COPs, HCAHPS, quality measures, the whole effort that's part of that process. And, again, I think that would be an area for us to think about and highlight.

Two more things. One on this area of creating voluntary high standards. I'm intrigued by that, but I'd like to be convinced it really does make a difference, because what I see mostly in voluntary high standards is the

putting up of billboards on highways about we're a Top 100 facility, we're a Top 10 facility, that kind of stuff. I really want to be convinced that it makes a difference and it's just not a way to brand and drive advertising campaigns for particular providers out there, and that would be helpful to see.

And then, finally, on focusing on lower-performing providers, you're right, in the Ninth Scope of Work, CMS did put provisions in there for it to -- whether it's nursing homes and some of them were special focus facilities, whether it's others. But the QIO could pick 85 percent. CMS picked the other 15 percent. That way the QIO couldn't cherrypick the ones so that they could look good in terms of the outcomes at the end of the day.

But if indeed when legislation goes through and we wind up with tournament-type models in terms of readmissions, all the kinds of things out there, we do really want to focus on those lower performers, I think, so the gap doesn't widen as part of the process. So I think that would be an area worth exploring.

MR. GEORGE MILLER: Thank you. And, Tom, you're talking about Dr. Ron Anderson who is president of Parkland,

and he and I currently serve on a panel dealing with disparities, and he's done a fantastic job. And so one of my recommendations, while we are going on this path, may be to bring in both those who have large populations of minority and socioeconomic, just to get a feel of those who've done things right and those who still struggle with it to see what they would think as far as a panel discussion or just to get some feedback and input.

But I do like the concept of strengthening the COP not for the minutiae, but where it could certainly lead to fundamentally quality change, and also holding up boards and organized medical staff in concert responsible for improving the standards.

I agree with Jennie that sometimes that information is reported just within an overview versus specific measures, and we could require that the board be very prescriptive in what information they must have at the board level and then hold accountability. And, again, using the organized medical staff as well.

I was kind of intrigued by Arnie's comments about the fire sale that they're going to lose accreditation. I served on the Joint Commission and chaired one of those

review panels when hospitals were about to lose their accreditation, they would come back, and they did go through just -- they got religion and they went through major changes. But trying to -- I'm not so sure, though, that's the right approach to try to improve quality, wait until they're just about on their death bed to do that, because that's all their focus. They don't do anything else. Everything else just drops. Maybe it should be, but maybe there's a better approach so they don't get to that point. That's why I like the technical assistance where it could do the most good.

Finally, Glenn mentioned earlier about the doors, so my question, while I think we're on the right path, have we opened all the right doors and looking at that discussion. Again, from my point of view, I would certainly like to hear from the Dr. Ron Andersons and the others who have safety net hospitals who struggle and listen to some of their challenges. I suspect that they don't have the infrastructure that Peter talked about, the data systems, and up-to-date data systems provide that information.

MS. BEHROOZI: This was a really interesting paper. I was not so interested so much in the COP side at

first, but, you know, listening to the conversation, certainly it's important to make the COPs meaningful. I still have a couple of concerns, and one of them is about access. We shouldn't be thinking, I think, about setting the bar too high too fast so that you end up, you know, with places that can't marshal the resources at the last minute to avoid dropping out. But, of course, that doesn't mean we want people to have access to low-quality places. No question about that.

So I really think that we -- I like the focus on the technical assistance. I like focusing on the low performers' readmission rates. The correspondence to the disparity issue reminds me of the recommendations, the distributional recommendations we made on the SNF side. You're not exactly focusing on how to make health care better for African Americans or Latinos or whatever, but you are doing a meaningful thing that produces that result, and also addresses socioeconomic disparities.

Also, I think the more we can encourage the application of resources to assisting those low performers, we can do things like get behind some of the issues that Bob was raising. But the way I heard what you were saying, Bob,

is that there are institutions in areas that don't have a robust health care infrastructure surrounding them in terms of, you know, follow-on support and that kind of thing. But there are other types of situations that providers in different areas face, like people traveling long distances or not having sufficient family support or nutritional, you know, the nutritional context, no place to buy fresh fruit or whatever, that those institutions have to deal with on an ongoing basis. It's not like you can fix them. You can't give them the technical support to help them build a network of outpatient support, whatever. There's other things that they're going to keep having to deal with, and by focusing on those institutions, not just their outcomes as a health care institution but the context within which they do it, you might learn more about what those challenges are and more of the types of technical assistance or whatever other kind of assistance you want to call it that they and their communities need going forward.

In terms of Jay's comment about the process and structure components of COP requirements, I don't know, maybe you need to have different process and structure measures. And I don't mean lower standards -- process and

structure requirements. I don't mean lower standards, but in different communities, you know, maybe in a rural community where people have to travel long distances, that institution needs to ensure transportation services, which you wouldn't have to do in an urban area, potentially.

And just on the issue of the support that can be provided by participation in a system, I just want to point out that we had a conversation a couple of months ago about consolidation and some of the negative unintended consequences of consolidation, and one of the other, I think, potential -- and that doesn't mean it shouldn't happen and it's a bad thing. But I think we need to, you know, think about that, but also think about whether systems then when they make their business decisions about the parts of their system to support or to shut down because they're a loser or, you know, it would require too many resources to restore them, how systems can be required to maintain access for all the different parts of the community.

MR. HACKBARTH: Just let me do a time check, Bill. How many people in the queue here? Seven. So we've got seven people. We've used up the allotted time, and so everything we do now has got to come out of the other two

sessions. So I ask people to keep that in mind.

DR. SCANLON: Then quickly. First of all, I think there's a link between the two things, as you said, the issue of assistance versus incentives, because you have to have incentives for people to want to accept assistance, and so we need to think about how strong the incentives are in anything that we do. And in doing that, we have to also make sure that we're fair about it, and we've had a discussion sort of at several points in this meeting about the variation, and not controlling appropriately for the variation is a real problem.

The other thing I'd say about the conditions of participation, I think that looking at the nursing home experience and thinking about what might apply and what might not apply would actually be good in terms of this because there's a rich experience with respect to nursing homes in conditions of participation. There's about 30 GAO reports over the last 10 years sort of on this. And there's three areas, I think. One, there's setting the standards. The second one is detecting sort of whether or not somebody has been in compliance. And the third is sort of enforcement, what do you do about it.

You know, I agree that conditions of participation generally are minimums, and as Mark said, we may be thinking that we can get to a point where we raise the minimum. That would be good. Detection is a real issue. In nursing homes where there's been more investment probably than any other sector, there's huge variation across the states in terms of the reported deficiencies and no one believes that they reflect an accurate sort of accounting of the deficiencies.

In terms of enforcement, you know, Arnie's experience of side -- and maybe it's because it's sort of the idea of threatened sort of expulsion from the program is so rare in hospitals that it becomes sort of a very sort of dramatic event. But then there's this question of whether or not there's a yo-yo sort of experience, which is that after they've come into compliance, you know, do they stay there? And in nursing homes, the experience is people come back into compliance, but then they're out again very quickly.

We also have in nursing homes the advantage of intermediate kinds of sanctions, and I think that's the kind of thing to think about here, too, which is that a death penalty is -- there's the reluctance on the part of the

person in charge to impose it. And so if you have intermediate sanctions -- and reporting is actually in some respects an intermediate sanction because it creates, you know, an incentive -- that you incorporate that into it.

So I think I'd strongly urge you to look at sort of the nursing home sort of experience because there are, I think, things that we can learn from this if we try to go down this -- if we decide to go down this path thinking about conditions of participation as one quality improvement sort of technique.

MR. BERTKO: Glenn, I'm going to respond to your first statement, which is I'd suggest keeping to a narrow focus of elements, pick up some quick wins with that evolutionary pathway. QIOs might be a good place to look, but it seems like it's a long time before we would get around to fixing them.

Thanks.

DR. BERENSON: Very quickly. On the QIOs, the IOM had a report. Senate Finance had hearings. My understanding is that the Ninth Scope is in a sense a response to try to get it right. So I think QIOs are important for us to look at, but right now I think it's

monitoring the Ninth Scope, and the real work is after that's over, when I think a lot of people will be interested in what the impact of a new way of doing things was.

The second point -- and I'll be very quick on this one -- about six years ago I presented to MedPAC Commission a model of value-based purchasing in which I had pay-for-performance as only one of, like, nine levers that the agency could use. And I regret, in fact, that the term for pay-for-performance has -- I mean, that value-based purchasing has now been appropriated to describe what I think is pay-for-performance. I think there's even things that have not been presented that can be part of the quality infrastructure, and I would urge us to have a broad look. I'm skeptical that we will get very far with just the pay-for-performance approach.

DR. MILSTEIN: Briefly, I think in terms of simplifying what a vision for what we might be after here, if we come up with a recommendation, we ought to ask ourselves does it do briefly -- does it successfully insert what I'll call sort of modern performance management into the DNA of U.S. hospitals. Let's work back from there. And I think Glenn's taking it apart into motivation and

resources makes a lot of sense to me.

On motivation, I think the problem is performance blindness. You know, fundamentally, it's -- you look at the survey results, you know, the majority of hospitals in the bottom half of the distribution believe that they're in the top half of the distribution. There's the problem with motivation. And I think the challenge is what's been referred to as "poverty of ambition" with respect to, you know, quality management that's both provider based, purchaser based in terms of, you know, what Medicare has articulated to the community, relatively low expectations, and I think, you know -- I don't know. You know, we also have to guard against it here.

I mean, for example, the notion that a hospital would have to get key discharge information to the patient's treating physician within 30 days, as Herb pointed out, is insane. And then if you sort of -- we have to, I think, guard against the notion of, well, the right answer is seven days. Maybe the right answer is seven hours, if it was like one of us or our mothers or, you know, whatever. And so it's -- guarding against poverty of ambition is, I think, very important.

I agree with Herb and I guess myself that I think, you know, you can't -- and I think with Bill, too. You cannot -- you know, the problem with having a nuclear weapon is it's very difficult to use. I remember when I used to be a director and had to make the decision regionally as to about kicking providers out of the program. You know, really tough.

And so I agree with Herb's logic that maybe the best way to approach it with the precedent we already have in place, and that is right now, you know, transplants, but it really -- that fits within a broader category of high complication risk, high variation treatments, you know, that are elective. There's a chance to move patients. I think that's probably our best bet and keeps us out of the problem that Bill mentioned, which is, you know, you can't really use a nuclear weapon. But most hospitals would care about whether or not they were permitted to serve Medicare patients with respect to high-risk, high-complication, high-variation conditions. I think that's a really nice -

And then in terms of resources, again, I spent my early years, you know, evaluating the precedent, the prior iterations of the QIO program, and I've had a chance to

interact with them more recently, and I just don't think that's our likely best vehicle for inserting modern quality management into America's hospital system. I think a much better model is one that has been advocated by others, certainly not myself, I didn't think of it, but it's this notion of taking what we can determine to be our very highest performers, you know, and then paying them to help those that are off the mark, because they really understand it, and many of the QIOs, you know, are not at this point in history the repositories of our best minds in modern quality management. There's no Virginia Masons, there's no equivalent of a Virginia Mason among the QIOs.

Then last, but not least, I think, you know, if we sort of think about where we're going to land on this, I think, you know, this is something I'm borrowing again from the American Board of Internal Medicine, but it's the notion -- let's not come up with something, you know, wild, but let's come up with something that when we look back on it we can say this is -- if this had been in place for five years -- once this is in place for five years, whatever we recommend, assuming it gets in place, any of us, any MedPAC Commissioner would be willing to take random assignment when

it came to which hospital they went to in their community. It's putting ourselves, you know, into the shoes of the beneficiary, and I think that may affect the shape of our decision if we sort of think of it that way.

DR. KANE: Yes. It's hard to know whether to just talk fast or cut down on what you want to say, so I'll try to do a little of both.

But first, I want to say, I think Conditions of Participation is too much of a sledgehammer, too hard to actually, you know, to kill a place. You do a lot of damage when you do that. And I think the example that comes to mind in my experience is tax exemption, whether or not to revoke tax exemption. And eventually, even the IRS had to come up with intermediate sanctions because it was just too heavy a hammer to drop on people and nobody -- so everybody got tax exemption, no matter how egregious their charitable behavior.

So I would think we could do an enormous amount of good to have CMS or somebody look through all the different ways that hospitals get recognized now, some of which are pure garbage. I mean, they pay $50,000 to get named a "best hospital" and whatever. If you look through all the

different ratings systems out there and all the flags blowing out in front of the hospitals saying, "We're in the top 100," I think the consumer is very confused by all of that and it would be useful to at least disclose the method by which hospitals are chosen.

I think just cleaning up the noise would be a huge contribution. I mean, I was shocked to find out that some hospitals are only recognized for particular performance levels by the different organizations by whether they pay the $50,000 to get themselves recognized. So there's something wrong there with that kind of a rating system. Just cleaning up the noise, making it an honest assessment, letting people understand how these different advertisements get created, I think, would be enormously helpful.

And then I think CMS or higher up would be -- it would be a good idea to create a recognition system that people believe in, because I think -- you know, I stopped -- I don't even listen when they say, U.S. News and World Report says blah, blah, blah. But there is clearly a need out there for some credible rating system on, I would say, major attributes of the kinds of things that Arnie was talking about.

And finally, I guess I'd like to say, because I looked at safety net hospitals now for this grant we're doing with the Commonwealth Fund, that DSH is not a particularly good way to find these hospitals. One of the biggest problems with the hospitals that serve the most disadvantaged is Medicare patients don't go there. So using the window of Medicare to find them isn't a particularly efficient way to do that.

So one thing I think we need to talk about is how much responsibility for the experience of non-Medicare patients do we want to take sitting on MedPAC. For instance, there's a lot of county hospitals out there who -- I mean, Medicare patients only get carried to them if they're unconscious and half-dead because they would otherwise say, "No, I don't want to go there." But these are the places that really need help and, frankly, serve a lot of minority and low-income people. So maybe DSH is not the best. I can give you more information on that, on the research that we've been doing. But I would say we need to clarify how much responsibility do we really want to take for true safety net hospitals, and if we do want to do that, we have to expand beyond just the Medicare population

because the Medicare population has freedom of choice to go someplace else.

And then lastly, thinking about hospitals and their span of control, I have seen some amazing examples of hospitals fixing what's missing in their community through a variety -- you know, expanding primary care, actually literally knocking on doors and signing people up for programs that will help them with their dementia or their depression or their various reasons. They actually evaluate their emergency room use and figure out why people are hitting it and go out and try to create programs to prevent the need to use the emergency room inappropriately. So there's all kinds of ways hospitals can try to target their populations if they're interested.

One tool to kind of look through, maybe get some ideas from, are the Community Benefit Statements that the IRS is now requiring hospitals to report, kind of getting a sense of what some hospitals are doing and try to get them in to talk about, here is how I address the fact that my local community doesn't have everything I ever needed. So that's just another resource to go to.

And finally, maybe we should ask some of the gurus

of hospital consulting who do help hospitals improve performance to come in and be a panel. There's a bunch of them. So have them come in and talk about what it takes to -- because I've been on those boards and I've tried to do it. It's not something I can see a QIO or even a government agency doing. Maybe we just need to create the incentives and maybe some standards of what kinds of things we'd like to see improved. But I really can't see that type of technical assistance being provided by certainly not a QIO, and probably not by CMS.

MR. BUTLER: How is your head doing over there, Jay?

[Laughter.]

MR. BUTLER: I thought I was going to be brilliant, because I had Donobedian in graduate school. I still have his book and I was going to use the structure process outcome framework, which you did articulate very well.

Both the Joint Commission and the Conditions have kind of had their roots in the structure, have slowly worked into the process area through things like tracer methodology, and still really is not in the outcome sphere.

I still think the core competencies of Conditions of Participation rest in the structure and maybe a little bit in the process, and contrary to some of the comments, having been on the receiving end of a termination letter on Conditions of Participation, knowing we're not really going to close, it was fairly effective. The basic look at facilities in some of these things, they do a good job on that and they bring some good people in when they do it.

Now, so my bottom line, though, the outcome side is we are, as Bob said, we're way underutilizing still the payment mechanism as the mechanism for outcomes. With the exception of the transplant and some of those areas, that is the vehicle. Think about what we've done in the past in Medicare. Think about what length of stay would be today without DRGs being inserted in the early to mid-1980s. Think about where core measures would be if we didn't start reporting them. And think about what readmissions will be as a result of -- and it's just one little piece.

Ultimately, we'll follow the dollars and it will be -- now take on top of it the stimulus dollars for IT, which are addressing, by the way, a lot of this same thing in the out years. You're going to have to perform to get --

you're not going to have just the systems, but you should have to perform, as well. Those dollars, I think, will have the largest impact on the outcome piece of what we're doing.

So actually, I view strengthening the Conditions of Participation on the structure side, perhaps on the process, but don't try to dip into -- the government is not the partners for process improvement and they're not where we're going to look to for expertise in general. We're going to partner best in class in our organizations, consultants, other areas, to try to match the payment system that is coming down the line.

DR. BORMAN: In watching all this, I've been going back to where we started this conversation. I'm struck by the traction that the whole notion of readmission rates got for us and got us to move in this area, and I think we have to ask, what is it about that that we liked and that plays backwards toward how we continue to get at those -- identify those kinds of things and how we attack them as opposed to saying, what should the process structure or whatever be and build outward.

It seems to me that what we like is that it seems to be an easily understood concept both on the policy and

regulatory side, but also to the consumer. My neighbors understand what is a hospital readmission. And maybe we understand it in a slightly different way, but it's easily understood.

It's relatively easily measured. We can quibble about who gets tagged with a particular readmission or whatever and the boundaries around what is for a related condition and what isn't, but again, it's something that's relatively easily measured.

A lot of people like it because it appears to be a system or a composite measure and that it is somewhat sensitive to how well some care is integrated, and so we like that piece of it very much. And we like the part that it moves money. It's tied, as best we can measure, to a fair amount of money that doesn't seem to be being productively and best invested of our health care dollars.

And so it seems to me that probably we need to look for several other things that feature those characteristics and then say, okay, out of those, if you want to fix something about it, how do you fix it? And there may be a few things that trickle out to the very basic structural part of COP and things like it. I don't know.

But COP, to me, in addition to being a structure thing, is it's not too dynamic. You can't just change the COP every year to reflect best thinking, new practice, whatever. So the COP and things like it, to me, are something that's the more static part of it that is moved only with a fairly major focus or reason, body of literature, or period of time behind it.

On the other hand, we need a dynamic piece to deal with the part we want to get at, which is changing on a relatively rapid basis, targeting the help to the folks who need it, whatever. Perhaps we try and transform the QIO system into that dynamic piece. I'm not sure we can, but maybe that's another way to think about it, is what out of all these other entities out there provide us a dynamic mechanism to deal with it, because COP, to me, seems pretty static.

MR. HACKBARTH: Okay. This has been a rich discussion but one that's a little hard to quickly analyze and organize. A couple quick thoughts. I want to go back through the transcript and talk to Mark and our presenters, but some thoughts that I have is that it might make sense for us to talk about a particular quality problem as opposed

to quality abstractly and sort of focus our exploration on readmissions or some particular problems as a way of giving it some concreteness.

We shouldn't quickly skip over the step of how to motivate improvement. One of the themes in this discussion is actually there are a lot of potential tools that might be used, and as opposed to just thinking about pay-for-performance or Conditions of Participation, it may actually be useful to think about how you would line up all of the available tools to attack a particular problem like readmissions.

There seems to be some general agreement that a particular challenge is how to elevate the poorest performers in a system and what can be done to support them in the improvement effort.

And then there are a bunch of questions about how to provide support. If, in fact, you want to help those institutions, the poorest performers, get better, there are a variety of different potential types of support that have been discussed here and some systematic analysis of what those options might be, you know, ranging from restructured, better financed, more focused QIO program to somebody

mentioned partnering institutions, high performers with low performers. We have talked previously about moving away from the QIO model to providing resources to institutions to buy consulting services of their choice. There are a lot of different potential tools there.

So I'm not sure that we have a narrow, very specific focus about where to go from here, but I think it's starting to take a little shape in my mind and I think will take more shape after we review the transcript.

Thank you for the guidance and leadership on this, and now we will move on to Part D. This presentation on Part D is informational, primarily, an update, and so it's important information I know people are interested in, but what I propose we do here is limit the questions to simply the round one very focused clarifying questions -- what did this piece of data mean, or I don't understand that chart -- as opposed to a more broad-ranging policy discussion.

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

DR. SOKOLOVSKY: It's my pleasure to introduce once again Jack Hoadley from Georgetown University and Elizabeth Hargrave from NORC at the University of Chicago. Jack is going to bring you up to date on Part D formularies

and benefit design in 2010.

But first, I wanted to look back at drug price trends under Part D, an issue that we have talked about a few times previously. Last year, we talked about price trends for 2006 to 2007. Now we have an additional year of data. First, I want to remind you of what we mean by prices.

Drug prices result from two sets of negotiations. Plans negotiate with manufacturers, generally for rebates, and they negotiate with pharmacies to be in their network, paying them an ingredient fee and a dispensing fee. This is a very simplified diagram of how the money flows. Pharmacies purchase drugs from wholesalers who, in turn, purchase them from manufacturers. Plans have a lot of leverage negotiating with pharmacies and they have limited dispensing fees over the course of Part D. But plans must pay enough to cover the prices pharmacies have to pay to buy drugs. And pharmacies have little negotiating power when buying brand drugs. The prices negotiated between the plan and the pharmacy determine beneficiaries' out-of-pocket costs, particularly when they reach the coverage gap, and how much they have to pay for each script.

Plans don't generally buy drugs directly from manufacturers. They negotiate, again, for retrospective rebates. Plans' ability to get these rebates depends upon the availability of therapeutic substitutes. If a plan can put a drug on a formulary in a preferred position and not its alternatives, the plan can get significant rebates from the manufacturers. These rebates are provided retrospectively and do not affect the price beneficiaries or Medicare pays at the retail counter. Plans can use these rebates to lower premiums, and remember, that also affects Medicare costs since Medicare subsidizes those premiums.

The trend for retail drug prices, that is, the prices plans pay to pharmacies, present a mixed picture. Overall, Part D drug prices based on individual drug products -- and that's the top red line you see up there -- rose 11 percent from January 2006 to December 2008. However, when you take generic substitution into account, and that's the bottom yellow line you see there, prices actually fell three percent over this period. Here, the shift in volume from branded drugs to their generic equivalents results in dramatic differences, and, in fact, it looks like a price decrease.

For the year 2008 alone -- and here, this is new data for you -- drug prices increased five percent, compared to six percent the previous year. When generic substitution is taken into account just for 2008, prices remain mostly stable in 2008, suggesting that there were fewer opportunities for generic substitution in 2008 compared to the previous years.

Last year, when we looked at biological products under Part D, we found prices increasing at a faster rate than other drugs, 14 percent for the first two years of the program. We thought that these prices occurred because there were no generic biologics and purchasers had little negotiating power to get lower prices from manufacturers.

This year, we looked at drugs in the six classes identified as of particular clinical concern. In these six classes, plans have to cover all or substantially all of the drugs in each class, although they can put the drugs on different tiers and use other forms of utilization management. Together, drugs in these classes account for 11 percent of claims and 22 percent of costs.

We thought that prices for drugs in these classes might increase more rapidly than drug prices in other

classes because, again, plans would have to cover them and might have less negotiating power. But, in fact, we found that the overall prices for the drugs in these six classes increased 12 percent from 2006 to 2008, only one percentage point higher than Part D drugs in our price index.

Then we decomposed the index into the six separate classes, and here, we found that antidepressants, and that's that blue line at the bottom there, which make up about 50 percent of the volume in these classes and which are now mostly generic, fell 11 percent over the period. You can actually see it really dramatically if you see that sharp cliff over there. That's one very popular antidepressant going generic and almost an immediate reaction there. Plans were very successful in getting beneficiaries to switch to generic versions of these drugs.

On the other hand, and now you see the white line on the top, prices for classes where there is little generic competition increased more rapidly. For example, for antineoplastics, which are oral drugs used to treat cancer, prices rose 31 percent during the period. Prices for antipsychotics rose 25 percent. And prices for AIDS drugs -- and these are not on the chart -- prices for AIDS drugs

rose 16 percent.

In the future, we may want to look at policy options that address cost growth in classes without competition.

But now, I'm going to turn this over to Jack Hoadley, who's going to discuss his findings on formularies in 2010.

DR. HOADLEY: Thank you. Thank you, Joan. This is the fifth year of the Part D drug benefit. This is also the fifth year we've been analyzing and reporting on formularies for you. The only thing I'm going to say about the notes is that we're presenting mostly enrollment-weighted results.

So first, looking at tier structures, what we see, as we have seen in past years, is that the standard benefit design that was built into the law, the 25 percent coinsurance, is really not used very often. It's gone down over the life of the program from about 22 percent of all enrollees seeing that kind of tier structure to seven percent in 2010. The most common tier structure is a structure that involves a generic tier, two brand tiers, one for preferred drugs, one for non-preferred drugs, and a

specialty tier for high-priced drugs, especially biologicals, and that tier structure now represents about 80 percent of all enrollees face.

What we are seeing more recently is some variations on that tier structure where plans are either introducing a second generic tier, a third brand tier, and some plans continue to have a second specialty tier for non-specialty injectables.

The other thing we've looked at is the cost sharing, and this graphic shows you that cost sharing has tended to go up, again, mostly because plans are not using the standard benefit. They're using flat copayments most commonly, although there's some trend towards more use of coinsurance in these tiers. But what you see here is a continued upward trend in each of the separate tiers, but especially the brand tiers. What's not shown in this slide is the specialty tier that is a percentage of coinsurance. That also continues to be higher, although actually for the PDPs, the median dropped back to 30 percent this year.

Now, we want to turn to the size of plan formularies, and I would note that there was a change this year in how CMS defined the universe of drugs that turned

out to have a little effect on our analysis. What we continue to show you is the formularies based on whether plans cover a particular entity. So we don't care if they cover only the generic and not the brand version. That still counts as covering that particular generic entity. We don't get into breaking up whether they cover all the different forms and strengths of the drug for this analysis.

And on average, it's been very constant over time. It continues to be the case that 2010, about the median plan, and weighted by enrollment, for PDPs cover about 88 percent of all chemical entities, for MA-PDs cover about 90 percent. And this graph shows you, however, that there is some range of variation across the plans. Plans have formularies that cover as few as about 65 percent of drugs and some cover 100 percent of all drugs. And it skews a little bit higher for the Medicare Advantage plans, although it's not a big difference here.

Next, we look at the question of whether low-income subsidized beneficiaries are in plans that look different than the plans that other beneficiaries are in, and there's two reasons we might think that could happen. One is that the cheaper plans that tend to be the ones where

low-income beneficiaries enroll might simply have smaller formularies is one of the reasons that they're charging lower premiums. It also may be that because low-income beneficiaries are not mostly facing the cost sharing differentials that the plans that tend to serve them may manage their formularies more tightly.

We see a small trend in that direction. It's not large. If you look at the overall median for benchmark plans versus non-benchmark plans, the average benchmark plan covers about 90 percent of drugs. The average non-benchmark plan covers about 83 percent of drugs. And this shows where beneficiaries are located regardless of whether they enroll in the benchmark plans or as some of them do if they enroll in non-benchmark plans. But again, you see a skew here where the dashed blue line is the non-LIS beneficiaries who are a little more likely to be in plans with more drugs covered.

The other important part of this analysis, it's not just a matter of whether the drugs are covered, it's whether there are restrictions on the use of the drug. So a drug can be listed on formulary but have a restriction on it and that may ultimately mean the beneficiary doesn't get the

drug or gets it only by going through some additional hoops.

And so we look at, again, whether utilization management measures are applied. There are three separate utilization management measures that CMS tracks. Prior authorization, which says whether -- that a beneficiary has to get the plans okayed before that drug is dispensed. Step therapy says that the beneficiary has to try a cheaper drug before getting the okay for a higher-cost option. And quantity limit, where the plan will restrict how many pills or how often the prescription is refilled.

And what we see here is that there's been a pretty steady upward trend over the years towards a higher share of formulary drugs having utilization management applied, where it's approaching one-third of all of the formulary drugs have some utilization management measure. Most common are quantity limits, but we're also seeing a significant increase in the use of prior authorization and step therapy.

I'm going to skip over this one, but it just identifies some of the individual drugs, and go on to the next on one the plans.

So you get some insight into the variation on formulary size and the amount of restrictiveness by looking

at these, which are the PDPs and the MA-PDs that have the highest enrollment in this past year and presumably will probably have the highest enrollment in the new year, the PDPs on the top and the MA-PDs on the bottom. And the two parts of the bar here, the lighter section of the bar shows the share of all chemical entities that are available to a beneficiary without restrictions. And here, restrictions means either utilization management restrictions or being placed on a non-preferred or a specialty tier.

Go to the next one. So you see here that among the PDPs, you can contrast an AARP Preferred, which has all chemical entities on formulary, with Silverscript Value Plan, which has considerably fewer drugs on formulary but actually has more drugs that are available on an unrestricted basis. So plans are taking on different strategies of how they treat their formulary.

And again, you see among the MA plans, Kaiser Permanente in some ways represents an extreme case of this. They have among these plans the smallest overall formulary, but actually one of the largest in terms of drugs that are available unrestricted, and this is consistent with the model of an integrated delivery system that tends to have a

tighter formulary but then have their doctors actually prescribe from it rather than enforce it at the pharmacy.

We did a whole series of checks on different comparisons of different kinds of plans. There's a few identified on this slide. I'm just going to mention one this morning. And that is that, curiously, the PDPs that offer enhanced benefits and charge higher premiums on the basis of those enhanced benefits actually have slightly smaller formularies than the basic benefit PDPs. Now, it may be true that they offer some non-Part D drugs, but it's kind of counterintuitive that they actually have smaller formularies.

And then finally, I want to talk just briefly about -- take a look at some of the individual drug classes, and here I show you the cholesterol drugs, where you have three generic drugs there on the top. And what the bars are showing you is the share of enrollees who face drugs in different tiers. So the blue tier here is the generic tier. The generic drugs are obviously mostly covered on a generic tier.

When you start looking at the brand drugs, you see the variations, where some drugs are less likely to be

listed on formulary and some drugs, like Lescol, when they are listed, are often listed on a non-preferred tier, compared to Lipitor, which is listed more often and far more likely to be listed on a preferred tier.

You can go to the next class, the antidepressants, which, as Joan mentioned, is one of the protected classes. Here, you see, as Joan referred to, most of the drugs are available generically, but nearly all drugs have to be covered. The only exceptions here are Lexapro, which has a special trade-off against Celexa. Most plans go ahead and cover it. And the other one I think here that's interesting is down near the bottom, not only the combo drug, which is not required to be covered, but Pristiq, which is the newest of the antidepressants, which even though it has to be covered by all plans and is, is a lot more likely to be covered only on a non-preferred tier.

And finally, just to mention briefly what happens with some of the specialty drugs, these are higher-priced, expensive drugs that are regularly taken by Medicare beneficiaries, and what's interesting is that although for many of them, they're consistently covered on a specialty tier, there are some, like Procrit and Aranesp, that are

less commonly covered on specialty tier and more commonly covered on preferred or non-preferred tier, and actually quite a difference between those two. And you see some of the other examples on here, as well.

So it gives you a sense, as you start to break down to individual drug classes, that you can actually see some very interesting comparisons of how individual drugs are treated, and with that, I'll stop.

MR. HACKBARTH: Okay. Let's start on this side. Any clarifying questions? Arnie?

DR. MILSTEIN: What is standard again? What does that mean, standard?

DR. HOADLEY: The standard plans? Oh, that's the 25 percent of coinsurance that's used by the plans that stick with the statutory -- in other words, they don't use tiers.

DR. MILSTEIN: Ah.

DR. HOADLEY: They're just covered at 25 percent coinsurance.

DR. MILSTEIN: Thank you.

DR. HOADLEY: So it's just that fixed seven percent of plans that do that, or seven percent of enrollees

that are in plans that do that.

DR. CROSSON: Just a brief clarifying comment, really, on Slide 9, Jack. Since you did bring up Kaiser Permanente and on the slide they have the smallest formulary, it would probably be worth a minute just to say how that is with respect to our plan, because we tend to use the term formulary in Kaiser Permanente a little differently than many managed care plans do.

So our formulary is constructed by physicians largely and is designed to guide physicians in their prescribing pattern. However, for individual patients, our physicians can write non-formulary drugs without preauthorization in most cases for most drugs. So actually, the effect of formulary is larger than that.

The irony of that is by doing it that way, it makes it easier to construct a, quote, formulary or a guide for the physicians because there's less concern about, well, what about if I have one patient one year who requires this other drug? Doesn't that need to be on the formulary?

CMS doesn't have a way to account for that model as they construct this sort of information. So I just wanted -- the actual availability on a beneficiary basis for

an individual beneficiary who requires a particular drug that is not on the formulary is much easier than this would depict.

DR. HOADLEY: Yes. That's certainly consistent with things we've heard in various interviews we've done. You know, every plan, in theory, any drug that's considered not on the formulary is available through an exceptions process. But I think it's true that in Kaiser Permanente, as you suggest, that's something that often the physicians can simply do on their own accord whereas in other cases, the physician provides the prescription, the beneficiary goes to the pharmacy, it's rejected at the pharmacy, and then there's a whole lot of processes that have to happen before the person can achieve that exception.

MR. BERTKO: Jack, Slide 4, please. This here, I believe, shows the change in cost sharing over the several years. I guess I want to see whether you'd agree with this. My interpretation of this is that while this probably comes from the bulk of plans, the 80 or 90 percent that have copays now, it also directly comes as a result of all the different initial coverage limits, the CCL -- those are the amounts at which the standard benefit plan changes being

ratcheted upward on an index as part of the direct part of the Part D benefit. And I'm just making sure you would agree with that statement that the copays tend to move up because those initial coverage limit and catastrophic coverage limits will move up with time.

DR. HOADLEY: Well, and anytime a plan is using flat copayments, obviously, they have to, if they are a basic benefit plan, they have to be actuarially equivalent to the 25 percent coinsurance within that initial coverage limit. And so you're right that as the overall cost of drugs increases, that the copays do have to go up to maintain that actuarial equivalent. So that is certainly part of what is driving.

I think what's interesting is that we see, relatively speaking, more increases on the brand drugs and to some extent on the non-preferred drugs than on the generic drugs, again, an attempt to continue to drive people towards using the generics.

MR. BERTKO: Let me be even more precise, then. Because the Part D standard benefit has cost sharing limits that move up with the drug index, that is, the average cost increase, that that's almost automatically to be expected in

there, and it does move up with the cost of brand drugs moving up, but it's also built into the formula for Part D and that should be recognized as part of the underlying driver for the upward tilt on that graph.

DR. HOADLEY: Yes, that's fair.

MS. HANSEN: Jack, this isn't part of your presentation, but it comes from the beneficiary perspective, especially when we have some of the biologics that hit that 31 percent increase. Do you have kind of the estimates of people who end up falling into the coverage gap changes over this period of time?

DR. HOADLEY: We're actually doing a project later this year, and for the Kaiser Family Foundation, we did an analysis for them in 2007 on the share of people who hit the coverage gap and some other characteristics of that and we're going to replicate that for 2009 data. But otherwise, I don't think anybody has yet reported on changes in how many people reach the coverage gap, other than between 2006 and 2007, and 2006 was an atypical year because a lot of people hadn't signed up at the beginning of the year. So that's a question we hope to be able to answer soon, but not yet.

MR. HACKBARTH: Okay. Thank you very much. Good to see you again, Jack.

DR. HOADLEY: Okay.

MR. HACKBARTH: Okay. So, the last session for today is Services Provided Under the In-Office Ancillary Exception to the Self Referral Law.

MR. WINTER: Good morning. Before I get started, I want to first thank Hannah Miller and Kevin Hayes for their help with this work.

At the October meeting, we discussed the in-office ancillary exception to the Stark Law and explored some ideas for modifying the exception. In today's session, we'll briefly review the exception, present results from an analysis of how frequently ancillary services are provided on the same day as an office visit, and present options to address self referral based on your comments from the October meeting.

The self referral law prohibits physicians from referring Medicare or Medicaid patients for certain designated health services to a provider with which the physician has a financial relationship. However, the law generally allows physicians to provide most of these

services, such as lab tests, physical therapy, and radiation therapy, and imaging in their offices. This is known as the in-office ancillary exception.

This slide highlights the key potential benefits and concerns about physicians providing ancillary services in their offices. The primary benefit is that it enables physicians to make rapid diagnoses and initiate treatment during a patient's visit. This could improve patient convenience as well as adherence to treatment recommendations.

However, additional capacity for services like imaging could lead to higher volume. In addition, physicians who invest in ancillary services for their offices have a financial incentive to order additional services. Several studies, including work done by the Commission, provide evidence of a relationship between self referral and higher volume.

The in-office exception has had a major impact on how physician practices are organized and in how ancillary services are delivered. Over the last several years, there's been an increase in imaging, lab tests, and physical therapy provided in physician offices.

In a proposed rule issued in 2007, CMS noted the migration of ancillary services into physician offices, and asked for comment on whether certain services should no longer qualify for the exception, so, services not needed at the time of an office visit to help with diagnosis or plan of treatment.

To examine one of the key arguments in favor of the in-office exception, we analyze the frequency with which ancillary services are provided on the same day as a related office visit. We used Medicare claims data to determine whether each outpatient therapy service, lab test, or diagnostic imaging study could be linked to an office visit.

We then examined whether the ancillary service was performed on the same day as a visit, up to 7 days after a visit, or up to 14 days after a visit.

Our sample includes services provided in both self referral an non-self referral situations.

This chart shows the results of our analysis for services provided on the same day as an office visit, the paper describes our findings for 7 and 14 days after a visit.

The first finding I want to highlight here is that

only standard imaging, in other words, plain x-rays, are provided at least 50 percent of the time on the same day as the visit. The second finding I want to highlight is that the less complex services, the lab tests and plain x-rays, are more likely to be provided on the same day as a visit.

More complex services, advanced imaging and outpatient therapy, are less likely to be performed on the same day as a visit.

The finding on outpatient therapy isn't surprising. Beneficiaries tend to receive multiple sessions of therapy within an episode, and the physician does not have to provide an office visit with each therapy service.

I want to drill down to some of our key findings regarding imaging.

First, the share of imaging studies performed on the same day as an office visit declined from 2007 to 2008, which is interesting given that overall imaging volume increased over this time frame.

And second, we found wide variation in how frequently advanced imaging was performed on the same day as a visit, ranging from 8 percent for nuclear medicine and MRI up to 25 percent for CT of the head.

And third, physicians who own imaging machines who can also order the studies are more likely to perform imaging on the same day as a visit.

In light of these findings, and in light of your discussion in October, here are some strategies that you may want to consider. We have classified these options into three main categories: excluding certain services from the in-office exception, developing payment tools to mitigate incentives to increase volume, and adopting a prior authorization program for physicians who self refer for advanced imaging.

In the interest of time, I'm going to briefly explain the rationale for each option in the following slides, but not dwell on the pros and cons; we can come back to those in the discussion, if you wish.

The first option is to exclude outpatient therapy and radiation therapy from the in-office exception, and by "outpatient therapy," we refer to physical therapy, occupational therapy, and speech language pathology services.

At the October meeting, several Commissioners expressed a concern that physician investment in therapeutic

services could skew clinical decisions about the treatment of patients.

In addition, one of the primary rationales for the in-office exception that enables physicians to rapidly diagnose and treat patients during an office visit does not seem to apply to these services.

Under the approach described in this slide, diagnostic tests that are generally not provided on the same day as an office visit would be excluded from the in-office exception. The rationale for this option is that certain tests are rarely used by physicians to make a rapid diagnosis at the time of a patient's office visit. Among imaging services, for example, we saw a wide variation in how frequently different types of imaging are furnished on the same day as a visit.

On this slide and the next slide we talk about payment tools that could be used to mitigate financial incentives to increase -- related to self referral. The approach described here is to reduce Medicare payment rates for diagnostic test performed by self referring physicians to offset the additional Medicare spending related to self referral. Arnie suggested this idea at the October meeting.

Studies by the Commission and other researchers have found that physicians who furnish imaging services in their offices refer patients for more imaging than other physicians, and other studies have found a similar effect with regards to clinical lab tests.

Under this option, on the option on this slide, Medicare would combine multiple services into a single payment through packaging or bundling, and packaging refers to combining multiple services provided during a single encounter by a single provider, whereas bundling refers to combining payment for services that are provided during multiple encounters potentially by multiple providers, and bundling or packaging both could create incentives to use ancillary services more efficiently.

Under the approach described here, Medicare would require self-referring physicians to participate in a prior authorization program for advanced imaging services, in other words, MRI, CT, and nuclear medicine studies. The notion would be to either focus on self-referring physicians who order many more advanced imaging services than there appears for a given condition or those who tend to order services that are not provided on the same day as an office

visit. Many private plans have been using prior authorization programs to control the growth of high-cost imaging services and to ensure their appropriate use.

So, to sum up, we've described our analysis of how frequently ancillary services are provided on the same day as an office visit, and we've presented some options to address concerns related to self referral. We'd like to get your feedback on whether you'd like to see additional analyses or data, which of these strategies, if any, we should pursue, or whether we should examine additional options.

MR. HACKBARTH: Thank you, Ariel.

MR. GEORGE MILLER: Just one quick one.

I believe I read, and I think you said, but I just want to be clear, that the additional tests did not improve outcomes.

MR. WINTER: We don't have data on whether they do or not. We don't have data on their impact.

MR. GEORGE MILLER: You do not. Okay.

MS. BEHROOZI: This is a question about the requirements, the legal requirements, for a service to fit under the exception.

In the paper, you cite the congressional record saying that the exceptions were expected to apply to tests where there's a need for a quick turnaround time on crucial tests, but then the three criteria, the three requirements, none of them refers to time. None of them say that the service has to be provided within a certain amount of time from the visit.

Do you know whether there was a particular reason for that?

MR. WINTER: The justification was in the congressional record. I think it was mentioned by Mr. Stark as rationale, but in the end, Congress did not -- only excluded a couple of services from the in-office exception, primarily DME services. So, the other ones they implicitly included and there is some discussion about whether CMS has administrative discretion to exclude additional services that were not specifically excluded by Congress, but what CMS was trying to do, I think, was to make sure there was a nexus between the physicians office and the service that was provided, which was why there were requirements for the service being provided in the same site where the physician treats patients or in a centralized location, that the

service be supervised -- provided or supervised by a physician in the practice or someone employed by the practice, and so forth.

So, I think it was not something that was considered by CMS when they developed the criteria, but there was some sort of hint that this came up -- this entered their thinking later on when they put out the rule in 2007 asking for comment about the in-office exception and they went back to the original -- what they viewed as one of the justification, which is that these are meant to cover services provided when the patient is in the office getting diagnosis and treatment. And so, they didn't specifically ask for comment on whether services that don't meet this criteria should continue to be covered, but they have not issued a final rule on that, or a specific proposal.

MR. BERTKO: Ariel, on slide 14, I know you were being brief in the interests of time here, but the last bullet there says, "represents many challenges." You correctly identified, saying earlier on that many private payers do this. I would say probably most at this stage. And after initial physician push back, these plans tend to run fairly smoothly at this point. So, are there challenges

that are specific to Medicare being able to do this or are you -- are there some other things involved?

MR. WINTER: So, I think there are some general challenges as well as some that could apply specifically to the program.

So, in terms of general challenges, these programs do have administrative costs, and they are generally higher for Medicare Advantage plans because there's a lot more volume involved, and they're also -- providers allege there are very high administrative costs on them to go through the criteria either to call up the program or to go through a Web-based application and then have to deal with appeals if they are initially denied.

There is still push back, we here from the provider community, that this undermines physicians' autonomy and that there are negative impacts on patients, that it makes them wait longer to get the service and it throws up an additional administrative barrier.

In terms of -- and there are also questions about whether -- about the soundness of the evidence on which these criteria are based. Providers allege that these are "black box" programs, that the criteria are not transparent,

they're not clinically based, those kinds of things.

In terms of challenges for the program, when GAO recommended in its report a couple of years ago that CMS consider front end approaches to managing, imaging, such as prior authorization and the administrator wrote a letter -- the Secretary wrote a letter back to GAO and they talked about things like how this would -- how the proprietary nature of the programs used by these vendors would interact with the public nature of Medicare; that's one issue. Another issue they raised is how denials would fit into the appeals process that the program has to maintain, and they also raised the administrative burden on the program, which we all talked about how it is faced with many challenges.

Another issue that I just want to raise is that the long-term impact of these programs on spending, it is still a bit unclear. We talk to plans, they have said their experience in the first year or two was quite good in terms of reducing volume, but then the prior trends tend to creep back upwards, and there is some evidence of this from a study that was published in a journal by Jean Mitchell about a year ago.

So, there are still a lot of questions both that -

- general questions as well as questions that are specific to the program.

DR. MILSTEIN: One question and one clarification.

Has MedPAC ever had a chance to hear from staff on whether or not there is or is not evidence -- reasonably robust scientific evidence as to whether or not radiology benefit management vendors do or do not, relative to a plausible control group, reduce -- moderate this problem? That's question one.

MR. WINTER: There have not been studies of the impact of these programs with a control group. The one published study I referred to by Jean Mitchell and Medical Care, Research, and Review looked at the experience pre- and post- to the programs. They found, for three plans, there was a decline in volume for MRI, CT, nuclear medicine in the first year. For two of the plans, volume went back up the second year, but was still a level below where it was before the program was implemented.

DR. MILSTEIN: You might want -- go ahead.

DR. MARK MILLER: In addition to that, I just want you and the other Commissioners to know we've had several meetings and conversations with the types of people who do

this, and they come in and sometimes more less, depending on the specific meeting, present the data that they can bring to bear, and they always have astounding evidence, but it's always exactly measured against what? So, it is the rigor of the evidence that is still, I think, a bit in flux.

I'm sorry.

MR. WINTER: Yes, and I think you want to have -- ideally, you'd want a control group, but it is difficult to select one that is equivalent in many ways to the population where the intervention is being applied.

And the other complicating factor that these things are widely prevalent in the private sector now. So, it is hard to find a population that is really not -- where this is not being tested, except Medicare fee-for-service population.

DR. MILSTEIN: My clarification simply -- thanks for remembering what I had recommended before, but I just want to clarify, it wasn't not recommending that CMS unilaterally reduce fees for physicians that have in-office ancillaries, rather, that CMS consider reducing fees for physicians who have in-office ancillaries, A; B, are not part of a care organization; and C, for which there is

evidence of higher use than their non-self referring peers after some reasonable risk adjustment. I had more of a scalpel solution in mind than a meat axe.

DR. CASTELLANOS: Ariel, first of all, this is good work and this is something that we really need to look at.

In your text that you sent out, you mentioned that, in the same day, studies that you excluded services that were provided as an inpatient but, more important, outpatient hospital setting, and I think it is terribly important to include that for a couple of reasons.

One, the hospitals are now employing a tremendous amount of physicians depending on what -- and we order -- that may be the group that Arnie is looking at that we can compare that group to groups of physicians that own the equipment, and I think that would be important to see if their practice pattern is different or maybe the same. So, I think you need to look at in-hospital -- not in-hospital, but outpatient, and for another reason, too, because there's a certain group of doctors out there that don't have equipment in their office and have to order it in a hospital, and we want to see if it's possible -- is there a

delay in getting it done in a hospital setting?

I hear rumors from the physician community that there is.

So, I think you need -- I'd like to clarify why you're not including that data.

MR. WINTER: So, the question we were trying to address is, for those ancillary services that are provided at physician offices, what percent were actually done on the same day as the visit, because that's one of the justifications for the in-office exception.

If we had included outpatient services -- I'll leave that aside. But that was the question we were trying to address, and that's why we excluded services provided in outpatient departments, was, of those services that are provided in physician offices, what percentage are done in the same day as the visit, because that's what relates to the -- that's what the in-office exception is trying to allow, or does allow. The decision is to provide these things in their office.

DR. CASTELLANOS: I agree with that and I think it needs to be looked at, but you need the compare group that Arnie just talked about, is what happens to the other

physicians that don't have this in their office? Is this a practice pattern? Is it a community standard? Is it society rules?

I think you need to grab that data from hospital-based physicians, and you also have to grab that data from doctors that don't have this equipment and how do they provide this treatment to the patient, and whether there is a delay. So, I think that data is important.

MR. BUTLER: Two questions. I think back to yesterday, Glenn, when you responded to Ron's question about the 1 percent on the physician payment and that the Part B spending in total was going up rapidly because of things like this facilitating utilization to increase overall compensation.

Now, I know you've shown in the past, for example, the percentage of income for cardiologists, 30 percent or something. I don't remember whether we've done it by specialty, but that would be an interesting thing to look at. What percentage of income now is based on tests and x-rays and their -- and it's a better sense of the compensation picture and the impact of this if it is not too hard to pull together, particularly in the primary care

areas where we're trying to find ways to make sure we have access and presence.

The second question relates to the therapy side, and I understand the distinction. We say, well, over utilizing diagnostic tools is not really all the harmful, necessarily, except in things like CT, but maybe therapy is. Now, I think that radiation therapy in my mind is a very different kind of error to make overutilization on versus the other outpatient therapies.

So, my question is, do you have any sense that the dollar is tied up -- if we were to make a recommendation around just the radiation be an exception versus the other therapies, what are the dollars in each of those two buckets, because that might change my answer to that significantly?

MR. WINTER: So, we've not been able to quantify what percent of radiation therapy provided outside of hospitals is in itself provided in a self referral situation or not. Most of it, undoubtedly is not, because radiation oncologists, when they order radiation therapy, it's not considered a referral as long as they got the patient referred to them from another physician. And so, therefore,

it's not considered a referral, it's not covered by the in-office exception. They can do this without any restrictions under the Stark Law. So, what we're talking here are physicians -- not radiation oncologists -- who order these services for their patients and benefit financially from them. So, that's -- it's a difficult question to try to quantify, but we can look into that. Physical therapy, it's also difficult to quantify between -- quantify arrangements that are self referral versus not, and that's because when a physical therapist in private practice, they can be independently -- they can be set up independently or they can be employed by the physician, but in either case, the claim comes from them, and so we can't tell whether there is this employment relationship or not. So, it is impossible to quantify -- to distinguish in that situation. What we can do is look at therapy services that are built into a physician service, and that is probably a self referral arrangement, and so we can look into that and get you those numbers.

DR. BORMAN: One of the times when this practice becomes important or has met a repetitive thing for me is in dealing with patients who live at a distance, and I think

there is an incentive to get as much done for them in a single visit. And just in terms of bringing them back -- and I realize you've broken this into same day and other days, but if I'm going to continue to treat them, generally speaking, I will vest more validity in the results if it is done in a system that I know the structure of, the quality of, whatever, particularly the more complex the test and the more interpretive piece to it, like advanced imaging.

So, I wonder if there's any way, even if just on some sort of representative subset of beneficiaries to look by ZIP Code or something about their home ZIP Code versus this particular piece or trying to figure out some way to tease out what is this group that is seeking care at a distance, because I think that would be a group that probably we would not want to disadvantage in some way, because if you're going to have to travel, let's get as much done as we can at that particular visit.

So, I just would ask if there is any way to do that that's not just 20 data steps for long-run -- for a short slide, that we consider doing that.

MR. WINTER: We could look into that.

One thing to point out is that there is a broad

exception just struck for rural providers, that's for rural beneficiaries. So, what we're talking about would not even apply -- any changes we're talking about to Start would not even apply to those providers.

DR. BORMAN: But I'm talking about a rural beneficiary and an urban provider, okay?

MR. WINTER: Okay.

DR. BORMAN: Because, just to give you a statistic from one of my own former practice locations, two-thirds of the patients that I operated on were from well outside the metro area that was our normal catchment area.

And so, for them to get a sono or CT or something, 150 miles away by people I don't know, the interpretive quality -- it just changes things a little bit.

And then, the second thing -- I guess maybe it's a little more of a comment, and maybe it relates to your final bullet there, but I think all the graphs we look at all the time about different kinds of services, volume, trajectory, I think comes back to this whole notion of, do we have accurate pricing in MedPAC speak, because maybe this is a subset of that issue and coming at this without some bigger problem, look at it, and solution to it, I think this

risks some ill will and hurting some subgroups that may in fact benefit when what we're trying to do is come at a much larger issue.

MR. HACKBARTH: So, this is our second, I think, session on this issue, isn't it, Ariel?

And so, as in the case of the earlier session today, I think we need to decide whether and how to proceed on this. From earlier conversations, it seems to me that there is fairly broad if not unanimous agreement that there is a problem here, that we've got rapidly growing utilization of some of these services. When I say "we have a problem here," I think the causes are multiple, as Karen is pointing out. The growth may be aggravated by self referral, but there are problems in the pricing. It is attractive because there are significant opportunities to make profit. There is the inherent incentives in fee-for-service and rewards for doing more. So, my sense is that there's agreement that we've got a problem.

Where I'm less sure is whether we have agreement that tackling the self referral rules is the best way to go after the problem, and I confessed ongoing ambivalence on that myself.

As you folks know, my own experience in healthcare delivery is in organized systems, where you bring services together and there is self referral, and so, the idea of saying, well the way to attack this problem is with organizational rules that prevent aggregation has always been something that troubles me a little bit. I think the problem is not organization, the problem is the incentives. The problem is in the payment system, the problem is in the pricing. If we had the payment systems that didn't reward excess volume, we wouldn't worry about organization.

So, it seems to me the Start approach has always been a second-best approach for grappling with the issue when you can't fix the underlying incentives, or you don't wish to fix the underlying incentives.

My own preference is always to do the incentives, but that comes with an important caveat, also. They are not going to be fixed overnight.

Ariel talked about -- we have some options for packaging, then we have the broader options for more fundamental reform, which I put under the "bundling" heading. As much as l like those paths, realistically I have to admit that they are difficult paths, and we're

talking years for them to be broad in their effect.

So, in that context, even if you believe as I do that payment reform is the best approach, do we need to do something on self referral rules as a stopgap? So, I think that's the question for us.

So, as we go around this next time, I'd like people to react to, yes, this is something that is worth investing our time and resources in or not. I'd like everybody to react to that.

And then, if you believe the answer is yes, Ariel laid out some different paths that we might take, and if you could identify your preference among the paths that Ariel suggested or if you have a new one to add, please feel free to do that, as well.

So, are those questions clear to guide round two?

Who wants to go first? We'll start on this side. I see some hands.

MR. BUTLER: You're not saying -- the problem is do we want to spend time on it. The answer was yes, unless you say what do we have to give up to make room for this. But I think we need to keep this in front of us. I think that even if it was a chapter without recommendations and

had more, some of these philosophies and ways you might think about it, I think it would be helpful. So I'm for doing that.

With respect to the specific tools, as I kind of already tipped my hand, I think there are some that can be excluded, and I would put radiation therapy, for example, on that list. You know, I'm not an expert clinically on all these, but I think there are some that we could articulate that should be excluded.

I think the payment tools, I'm less clear about how to apply those, and we get into a very technical kind of thing that we may not be well equipped from a staff perspective to really finally do that, but the concept is, I think, a good one.

I think one way to address maybe the pre-authorization is to do something along the lines we talked about yesterday in home health and so forth, and maybe that there is a screening that you could do that would flag some of the utilization patterns that are just way out of the norm. And you could potentially use that as a mechanism to then, if you are outside this norm, it could merit then, you know, the requirement for pre-authorization. I'm not sure

that's exactly the right concept, but you get the theme, so that we begin to at least shine light on the outliers and learn more about what is happening, which in turn could inform payment tools and how they might be developed.

DR. CASTELLANOS: Glenn, I agree with your comments. We have a problem here. There's no question. There's a definite relationship between ownership and increased volume.

Now, there are a lot of reasons for that, and, you know, we don't want to just pick one thing. We have to pick all of them. And one of the questions I asked you yesterday and you elucidated very nicely is that the reason we're getting a 1-percent update is because of perhaps something like this. And there's no question -- and I've made the comments before -- that if I'm not in business today, I can't take care of today's patients or tomorrow's. And some of this behavior that we see in the physician community is a reflection of the reimbursement rate issues.

Now, Glenn, you and I have had a lot of talks about that, and I think we need to appropriately pay for outcomes and quality. And we both agree on that.

Now, what kind of things do we have already in

line? Well, we do have some feedback, and that's just started last year where we're going to individually feed back -- or CMS is supposed to be able to feed back to each physician, especially the outliers. And I think that may help.

You know, whether the physician community likes it or not, the DRA has been successful in some respects for decreasing volume use in radiation therapy. So what Karen said is to pay appropriately, and I think that's really -- it's pricing, and we need to look at that.

What we want to do is not hurt the beneficiary. We want to make sure the beneficiary has access. We want to make sure that we don't increase cost to the Medicare system. And what we want to do is not throw out the baby with the bath, but try to see how we can better improve what we're doing now to pay more appropriately, continue the access, and continue the quality that I personally believe in-office exceptions provide to the patient.

DR. KANE: I support trying to explore where we might most effectively use either payment systems or prior authorizations to curb excessive use, and I'm wondering if there isn't some way to do an all-payer database on some

place, because some payers already do prior authorization or have employed physicians so they don't personally gain when they order up these things and perhaps create community-based profiles of appropriate use for high-cost or high-volume potentially inappropriate use technologies and ancillaries. And, frankly, one of the ancillaries that I've heard is abused is radiation therapy, but maybe I'm missing something. But the cyber knives, for instance, are apparently being used -- when a physician buys one, it costs a million bucks, and so they really want to use it a lot to get the return on it. So I don't know. There's a huge controversy -- I think I told Ron about this -- about cyber knives being used for prostate cancer.

So I don't know. Maybe you just need to look for potentially inappropriate usage in radiation therapy for, you know, being used for cancers that had better, more proven technologies in the past, and try to pick that up in even in claims edits or something. But I think it would be useful to have an all-payer subset, all-payer data set so that we can actually look at where physicians, even individual physicians, who may be constrained by one payer but aren't constrained by the other, what their self-

referral pattern looks like, and just get a sense of where it is and who we should target and for what types of services. Then maybe that could even be built into claims data to do either prior authorization or refuse to pay for the service altogether.

DR. MILSTEIN: Let me make a comment. I do think we should recommend specific solutions. I think there are a variety that make sense to me that have been proposed by others. And one of the reasons I think we ought to move on it is that in some ways it's instrumental to our overall vision of, you know, why in the world would any hospital and physician that is doing extremely well under fee-for-service ever want to take, you know, longitudinal -- you know, financial and clinical outcome risk like we want the accountable care organizations to do if the living is too -- if it's too easy to make a fortune, you know, under the current fee-for-service payment system, and I think, you know, there is a sense -- maybe in some cases not of a fortune, but of at least a very substantial opportunity for what I've heard some physicians refer to as "easy pickings." I'm talking about some of the cardiologists who have shared with me privately -- and I don't mean to pick on them

because it applies across the board -- that, you know, they've gone from a world in which they were primarily trying to survive on E&M codes and interventional cardiology to a world in which, you know, half of their revenue is coming from all the bells and whistles and toys that they've got in their offices. You know, it's one of these sort of egregious changes, and there's no reason why those parallel changes would not happen in many other sectors.

But the challenge, I think, as we've talked about, is as we make -- as John has suggested, make the survival conditions in fee-for-service less pleasant, I think, you know, my earlier comment stands, sort of doing it in a way that we don't inadvertently, you know, punish the good, really home in on those that really, you know, appear to be engaging in the adverse behaviors.

So, anyway, really two different suggestions.

DR. BERENSON: Well, Arnie just gave my number one, which is we only get to changing incentives when we create a political environment in which people don't want to preserve the existing, and so I think we have to address this topic.

The second point is that I was impressed by the

research that I think is just the beginning of what we need to do on the diagnostic tests that are usually not provided. I think it has some potential for providing us a marker. I'd like to have more granularity. I mean, that may be CPT level and for more services. I'd like to know -- I mean, there's an MRI and there's an MRI. It may well be that in some situations it is commonly done at the same time, and in others it's not. I assume you could do that analysis at the CPT level. So I think with more granularity we might have -- and I'd be happy to talk to you about some other services I'd be interested in looking at also.

Then I think the final piece on the prior authorization, don't we have a position that calls for having radiology benefit management not just for self-referral for advanced imagine? We haven't gone that far in the past? Because I don't think this issue is just for advanced imaging. It's just an issue of self-referral. We have lots of referral going on, and so I think we should look at it here in the context of both self and outside referral in advanced imaging. I think private plans see the problem in both categories.

To me, though, an important part of this would be

-- and it picks up what Peter said, and others have said -- is our ability in Medicare to do what I guess is called gold carding by private plans. Some of them can do it, and some of them claim administratively they can't do it, which is getting a profile of a practitioner of a practice and say they never get overturned, and why are we spending all this effort hassling them and their patients when they have met the test, and so to concentrate the administrative oversight where it would be much more efficient. And then so, Karen, for your patients who are coming from a rural area and you've got a good track record, you get to order that CT or that MRI or whatever it is at the same sitting, and it may well be some other physician doesn't get to do that, and that if that's a form of recognition of different physicians' performance, then great.

So I would like us to be much more tactical about how we, if we went this direction in Medicare, could do it and, in fact, have physicians be supporting this thing, because we're not going to sort of review everything that they're all doing. We're really going to target.

DR. CROSSON: Yeah, I mean, my comments are very similar to Arnie's and Bob's. You know, I think if we look

at the area of excluding services, there probably are some areas we could get to there. But my suspicion is that we're going to have to be very granular and very focused because there's a lot of clinical complexity to this. In the area of outpatient therapy and advanced imaging, I think there probably are some things that can be excluded. I think, though, for example, if we get into laboratory testing, it gets a little trickier. We might find, for example, if we looked at, to get very granular, the performance of serum potassiums, that the majority of those to monitor patients with hypertensive therapy are done on different days than an office visit. But that wouldn't mean necessarily we would want to exclude the ability of a physician to do an acute serum potassium because there's a value to having those tests done by the same laboratory over time.

So, I mean, this is not a major cost area, but I'm just saying that if we're going to think about excluding, we're going to have to get pretty specific and in some cases rather clinical, and I think it's going to make it complicated.

I think, as Glenn does, that the issue of payment seems to be the most productive area, and I agree also with

Arnie and with Bob that if, in fact, the payment rate for these services was appropriate and there was not an extraordinary profit margin, then some of this problem would go away. People ought to be able to perform these tests and have their costs covered with perhaps some added payment to make up for the need to replace equipment over time and the like. But it should not be something that transforms an entire specialty, you know, over a period of five to six years. So it would seem to me that that is a natural area to go, and then when we can, to move to more advanced payment techniques like bundling and packaging or incorporating this into more prospective processes.

And my last point is that, you know, the issue of prior authorization, as everybody well knows, is not my favorite.

[Laughter.]

MR. BERTKO: Just a quick couple follow-up comments here. On the payment reform stuff, it strikes me that any amount of payment reform we do might be running in a parallel sequence with medical homes, with bundling, with ACOs. So maybe we wait for those things to get there. In the meantime, making a statement, I like Bob's comment, gold

carding rewards good behavior, and then what Ariel has shown with the lack of same-day type of stuff, it might make sense to make that statement, that things that are not same-day performed should now fall under some expanded Stark rule on this to at least, you know, put a stake in the ground that says don't -- or do less of that in the same point.

MS. BEHROOZI: Are you and I the only lawyers left here?

MR. HACKBARTH: I think so.

MS. BEHROOZI: Okay. So I'm going to trot out the lawyer hat here. Keep me honest.

So there's a law that says that there shouldn't be, you know, profits made off of -- or there was a concern, I guess, about profits made off of self-referral. And then there's an exception to it that seems to have kind of swallowed the rule. And you have demonstrated there are some, you know, consequences that would seem to have been exactly why the law was enacted in the first place.

CMS asked whether they should reconsider the exceptions and maybe look more at things like the time of the service provision, which seems to me exactly what was originally intended in the law. Go back to the original

justifications of the urgent need for diagnosis, for compliance, which, you know, has to do with distances that people travel and things like that, really be very concrete about what those justifications are, and then create rules that will enforce those exceptions. Those are exceptions that are needed to the law. The law was needed. Exceptions are needed. But the way it is now, this business of being in the same building and, you know, billed by the physician doesn't seem to me to have anything to do -- I don't see why, you know, occupational therapy should be an exception to the law as it's written.

I'm not saying that it's a bad thing -- you know, it's my judgment it's a bad thing that occupational therapy shouldn't be provided by somebody who is employed by an entity, an integrated entity that a physician has an owner in. But then they have to change the law or come up with a different rationale than this in-office ancillary exception that seems to have, you know, really outgrown it.

And then I think you will have some presumptive things, whether it is same-day or whatever, and I think the physician would have to certify why that thing was necessary that same day so you don't have a proliferation of office

visit billing, which you kind of flagged in the paper, to justify the provision of the therapy or whatever on that day. And then you would also have certain -- so then if you had a prior authorization requirement for everything else or for a certain range of things, then you could have exemptions, presumptive permission for people who've demonstrated not only that they're good actors, but that their need to do these things fulfills the purpose of the exception, the original underlying rationale.

DR. DEAN: I'd just echo many of the things said, especially what Mitra just said. It seems to me that the quickest way to get to this would be to narrow the range of things that are included, because it's pretty hard to understand how physical therapy or radiation therapy would have to be done on that day in order to deal with a particular condition.

I think limiting it to diagnostic interventions certainly would make sense. I'm a little uncomfortable with the idea of using the test that whether or not it is usually done on a different day, because I think as Jay said, there are some tests that may commonly be done not necessarily at the same time, but there certainly are times -- and the

potassium is a good example -- where it really is necessary to do it on that day if you're going to give reliable care. So the one-day test does both me a little bit. But I would think the first step is to narrow the range of things that are included to really involve things that you can really justify are needed to make a diagnosis, and then -- but that's only a start, and obviously the payment issues are probably much more important but also a lot harder to do.

MR. HACKBARTH: Okay. Thank you, Ariel. Obviously, we will be coming back to this.

We'll now have a brief public comment period, and I'd ask those who wish to comment to first identify themselves and their organization, and limit your comments to no more than two minutes. When this red light comes back on, that's the end of your two minutes.

MS. TRUJILLO: My name is Sylvia Trujillo. I work for the AMA as a Legislative Counsel and a Senior Attorney. I work on fraud issues. But I'm actually here today to talk about my personal experience and what it means when a frail beneficiary does not have access to the type of accepted services in a physician's office.

My mother is a Medicare beneficiary with a number

of chronic conditions. Last year, she was diagnosed with two very rare conditions. Left undiagnosed and untreated, these would have been fatal. She remains medically fragile and continues under the care of specialists and requires monthly lab work. She is essentially the poster child of what Medicare is dealing with, individuals with multiple chronic conditions and declining health.

Last summer, her condition began to rapidly deteriorate. Because of her extreme fatigue and disorientation, simply making it to her physician's office was a challenge. After running into many brick walls in my efforts to help my mom, a coworker found me in my office literally in tears because I could not physically transport her to her physician's appointments and to have her lab work done in a separate location, as ordered. She suggested I hire a care provider. I did, an LPN. She was tasked with taking my mom not only to her physician appointments, but to the various lab locations she needed to go. Instead of simply managing the names and locations of her physicians, we had to also keep track of the lab work and the locations. This was enormously time consuming and exceedingly expensive. In addition, the LPN was responsible for

ensuring that the lab results were delivered to the treating physicians' offices before her follow-up visits because they weren't arriving on time or weren't done correctly.

During one of my mom's hospitalizations, she was prescribed Heparin and her blood platelet count dropped. Subsequently, after her discharge, a hematologist ordered labs to be run to see if she had Heparin-induced TP. Despite going to an independent lab no less than twice for draws in order to determine whether or not she had this condition, we showed up at the physician's office and the labs had not been delivered and had, in fact, not been run. We ultimately went to a third laboratory and the physician had to give us the results over the phone.

My mother continues to be transported to different locations for her lab work and her physician visits. She has 17 different medications which we have to update every time she makes a lab visit.

The in-office exception is commonly defended as a convenience for patients. It is not about convenience at all. It is about coordination and access to care and outcomes. When these services are not available in your physician's office, it means you are shuttled to multiple

locations and dealing with many strangers, all of whom require detailed information about you and your care. When you are ill, facing these extra hurdles can be the difference between receiving the care you need or not receiving it.

This was true in my mother's case. She did not receive the care or diagnosis that would save her life until my family and I stepped in and spent thousands of dollars and innumerable hours trying to ensure basic care --

MR. HACKBARTH: I need to interrupt.

MS. TRUJILLO: Okay. Thank you.

MR. HACKBARTH: I feel bad about doing that. It's an important story, but we -

MS. TRUJILLO: So in short, the answer is --

MR. HACKBARTH: The "in short" first and --

MS. TRUJILLO: Right. In short, the answer to this question, I think, is that it's very complicated and that simply narrowing the exception means that you are narrowing access to care to many vulnerable and underserved beneficiaries.

MR. HACKBARTH: Okay. Thank you.

DR. MARK MILLER: [Off microphone.]

MR. HACKBARTH: Let me just remind people, I know it's frustrating that this is a limited opportunity, but I'm really going to have to limit it to now five minutes, because we have got people who have to catch airplanes. This is not your only opportunity to communicate with the Commission. The staff are the best way to do that. You can also go to our website, and we have a place on our website where you can make comments and include anecdotes, if you wish.

MR. KAZON: Thank you. I'll try to be brief. My name --

MR. HACKBARTH: Excuse me, you will be brief. Two minutes, I'm cutting you off.

MR. KAZON: Absolutely. I will succeed in being brief. My name is Peter Kazon with the Law Firm of Alston and Bird. I'm here on behalf of the American Clinical Laboratory Association today. ACLA is a not-for-profit organization that represents clinical laboratories throughout the country.

We appreciate the Commission's recent attention to the in-office ancillary services exception, and laboratories are very concerned about this exception, and in particular

with regard to anatomic pathology services, which as the Commission knows are the analysis of tissues that are for cancer and for other services.

In recent years, there's been a growing trend by which physicians capitalize on the in-office ancillary service exception by purchasing or contracting for the professional and the technical components of anatomic pathology services or by setting up an in-office laboratory to provide those services. In each case, the physician group obtains the pathology services, then is able to bill for the full professional component or the technical component to Medicare.

This results in a profit to the ordering physician on each service ordered and such arrangements lead to increased utilization and higher costs. These types of arrangements are generally made possible by the in-office ancillary services exception.

To follow up on the discussion that's been happening here today, while other sorts of services frequently are performed in the physician's office and are performed while the patient is present in the office, anatomic pathology services are never performed while the

patient is in the office. Because of the fact that they are done on a biopsy, there's a technical and a professional component, they have to be done at a minimum overnight and they may take several days. Therefore, the rationale for the in-office ancillary services in other situations does not apply to anatomic pathology services because those are never done while the patient is present in the office.

We encourage the Commission to continue to look at this issue and we thank you for your attention.

MR. HACKBARTH: Okay. Thank you.

MR. LEVIN: My name is David Levin. I'm a retired academic radiologist. I'm a member of the American College of Radiology, but I'm not necessarily representing their viewpoint.

I'd like to speak to the issue of self-referral and advanced imaging, and by advanced imaging, I mean MRI, CT scanning, PET scanning, and other nuclear medicine types of scanning.

When the Stark Law -- my understanding is that the official title of that exception is the in-office ancillary services exception. Now, if you think about it, things like MRI, CT, PET scanning, and other nuclear medicine studies

are really almost never ancillary to an office visit. These are things that are usually done on an elective basis and they can be referred to a hospital radiology facility or an imaging center or what have you.

The original intent behind the in-office ancillary services exception was, let's say, for example, a patient comes in having fallen down and twisted her ankle and she's got pain and swelling. The question is, is this a sprain or is this a fracture? So if the physician has an X-ray machine in his office, that X-ray of the ankle is ancillary to the office visit. I think having X-ray equipment in the office and perhaps ultrasound equipment in the office is legitimate. But I don't think that things like MR, CT, PET, and nuclear medicine are truly ancillary to that office visit.

So my recommendation to the Commission would be to exclude those kinds of services from the exception. Thank you.

MR. ADLER: Thank you. My name is Dave Adler. I'm the Assistant Director of Government Relations with the American Society for Radiation Oncology, ASRO. I'll be very brief. I just wanted to thank you for your continued

examination of the in-office ancillary services exception. We agree with many that have voiced it around the table that radiation therapy should not be part of the exception. I won't go into all of the reasons why. You all have, I think, articulated it very well.

I do want to address one point, Chairman Hackbarth, that you raised regarding the organized systems. While we would like to see radiation therapy removed from the exception, I think within ASRO, our concern is with the arrangements that are designed around profit, frankly. The systems you referenced, the Mayos, the Billings of the world, we don't believe those are designed around profit. Those are designed around better care. Perhaps if you make recommendations in this regard, it would be appropriate to address those important situations. Thank you.

MR. HACKBARTH: [Off microphone.] This will be the last comment.

MS. RAU: Thank you. I'm B.J. Rau [phonetic]. I'm an academic radiologist. And again, I'm a member of the American College of Radiology but do not necessarily represent their opinion. This is my opinion and from the work that we have done.

When you think about it, most M.D.s do not own their equipment. It's a minority of the non-radiologist physicians who see patients and self-refer and have their own high-end imaging equipment, i.e., MRI, CT, or PET. And we also know the data shows that they utilize imaging at a much higher rate. And knowing that that's adding to higher utilization, that there's only a limited pot of money, as there's more spending being done on imaging, it takes away money from other physician services, such as E&M, et cetera.

And when it comes to access, it's really a minority of the physicians that own their equipment, and we are talking about access for those Medicare beneficiaries. So the vast majority actually don't have that convenience factor to start with. Thank you.

MR. HACKBARTH: Thank you very much, everybody.

We're adjourned and I'll see you all in March.

MR. BERTKO: If everyone could please remember to give me their blue sheets, if you're interested in reviewing a chapter.

[Whereupon, at 12:01 p.m., the meeting was adjourned.]