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 13, 2011
9:45 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
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MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
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AGENDA PAGE

P R O C E E D I N G S [9:45 a.m.]

MR. HACKBARTH: Okay. It's time to get started. Good morning and welcome to our guests in the audience. As I think everybody knows -- certainly the Commissioners, I hope everybody in the audience -- today and tomorrow's meeting will be devoted principally to final votes on our update recommendations for this year. Since we last did update recommendations a year ago, obviously there has been a major change in law, that being PPACA, and I wanted just to make a few introductory comments to put our update recommendations in the context of PPACA.

There has been, of course, much discussion of the fact that among many other changes, PPACA made important changes in the Medicare program, including changing the updates for the various providers who serve Medicare patients. What PPACA did not do was change MedPAC's mandate. Our mandate continues to be what it was before PPACA, which is to year by year make recommendations to the Congress on the appropriate update in payments for the various provider groups, doing so with an eye towards payments that are appropriate for the efficient delivery of high-quality services to Medicare beneficiaries.

I want to emphasize year by year. One of the features of the Affordable Care Act that has received a lot of discussion is that it provides for ten years a formula update for providers related to market basket minus productivity. That is important, but it in no way alters MedPAC's charge, which is year by year. We're not talking about what the rates should be for the next ten years. Our responsibility is to make a recommendation to the Congress for the next fiscal year, and we will do that as we have done in previous years using what we refer to as a payment adequacy payment framework that takes into account a number of different factors, where available, information on provider financial performance, margins, but also information about access to care, access to capital, quality of care, and the like.

Having said that, by changing the budgetary baseline, what PPACA does is change the baseline for calculating the budgetary effect of MedPAC recommendations. And so we'll make a recommendation for each of the provider groups. That number will be compared to the new budget baseline established by PPACA, and there will be either a cost or a savings score attached to it based on the new

baseline.

As we talk about our update recommendations, one of the things that you will hear is that we are beginning our discussion of each provider group, whether it be hospitals or physicians or home health agencies, with a presumption of no increase in prices. That is the starting point for the discussion. The end point may be very different, but we don't believe that there ought to be any presumption of an increase in prices.

Now, some people might be tempted to characterize that, report that, for those of you in the audience who are reporters, "Oh, MedPAC has somehow disagreed with the Congress on market basket minus productivity." I would urge you not to make that comparison because it's an apples-to-oranges comparison. If you want to compare MedPAC's recommendations to what Congress has done, you compare our final update recommendation, whatever that number may be, with what is in the congressional baseline. And we will do that for you and help you make that comparison for each of the sectors.

One last word about the context. This meeting is principally focused on the update in the base rates for the

various provider groups, but that is but one of three instruments of payment policy that we discuss at MedPAC. A second is how the dollars are distributed. So the way we think of the update is that it establishes the size of the pool of dollars available for hospitals or for physicians or for home health agencies, et cetera.

A second critical issue is how those dollars are distributed, and from time to time we will couple an update recommendation with a recommendation about the distribution of the dollars. So an example of that in the past has been, in the case of physician services, we have recommended a bonus for primary care physicians. That's an example of a distributive recommendation that we linked to an update recommendation in the past.

In the case of home health services and skilled nursing facility services, we've linked update recommendations to recommendations about how to change the case-mix adjustments systems that distribute the dollars based on the needs of different types of patients. That's an important distributive recommendation.

The third lever that we talk about but will not focus on so much in the next couple days is the payment

method itself. MedPAC in recent years has spent a lot of time talking about the need for payment reform, which is -- we use that term, "payment reform," to talk about more fundamental changes in how we pay providers. Examples of payment reform would be medical home and moving away from simply fee-for-service payment for physicians to include a per patient payment as well as a fee-for-service payment. That would be an example of payment reform. Or bundling around a hospital admission, including not just the hospital inpatient services but also physician services and post-acute services within some window, that would be another example of payment reform. ACOs would be a third.

So the fact that we are focused in the next day or so principally on updates should be in no way construed as, oh, this is the most important thing in Medicare. The distributive recommendations and payment reform recommendations are equally, if not more important in many cases. But the update process is a fundamental part of MedPAC's mission, and Congress has charged to us, and that's what we will be doing for the next couple days.

So, with that preface, let's turn to the initial presentation on physician and other health professional

services. Cristina.

MS. BOCCUTI: Okay. So this morning Kevin and I are going to summarize the discussion that we had last month and also address some of the questions and issues that you raised during the meeting.

First, just a background on services provided by physicians and other health professionals. These services include office visits, surgical procedures, and a broad range of diagnostic and therapeutic services. Keep in mind that providers can furnish them in all settings, not just in offices.

In 2009, Medicare paid about $64 billion for these services, and among the 1 million practitioners that are in Medicare's registry, about half are physicians who are actively billing Medicare, and the other half include other health professionals such as nurse practitioners, physical therapists, and chiropractors. I'll note that about 90 percent of the fee schedule billing does come from physicians, but the other 10 percent come from the other health professionals. Then keep in mind also that almost all fee-for-service beneficiaries received at least one fee schedule service in the year.

We're going to be going kind of quickly because I want to make up a little bit of time, so please feel free to ask questions when that time comes.

Before I get to the payment adequacy analysis, I want to reiterate two underlying contextual issues that you all have raised, and I want to ensure you that we're going to be including discussions of this not only in this chapter but in future work.

So first is about enhancing access to primary care. The Commission will continue to discuss ways that Medicare can promote primary care to sustain beneficiary access to it. Good, accessible primary care is essential for a well-functioning delivery system. And it's also crucial for patient management, particularly for elderly and disabled patients that have chronic conditions.

The second issue, of course, is regarding the SGR. The Commission recognizes that in addition to budgetary implications of overriding it, Medicare is facing another cost related to the SGR, and that is, the frustration of providers and their patients that are stemming from the uncertainty of the Medicare payment for those services. There are looming cuts, as we know, and temporary fixes that

have gone on in the last couple years, and we hear -- and I want to ensure that we understand that this is problematic for providers and for the patients, and it's even burdening CMS resources.

So looking at the SGR specifically, changes to payment policies that we can explore as we continue would want to retain the advantages that expenditure target approaches have while doing its best to minimize the disadvantages that the current SGR system contains.

Now, this slide here is about the payment adequacy framework that you're going to be hearing about throughout the day for all other sessions. But since we're the first ones to go, we want to put this list up here.

I remind you and the audience that each year, as Glenn just stated, as required by statute, MedPAC makes recommendations to Congress on payment updates for most health sectors. To come to this recommendation, the Commission deliberates and makes a judgment as to the adequacy of payments in each sector.

So today you are going to discuss whether the 2011 payments are adequate, taking into account the indicators that we have here on this slide. So those are going to

carry through each time. And, in addition, referring to that last bullet there on payments and costs in 2011, I want to emphasize that MedPAC is required to consider the costs of efficient providers when making their update recommendations.

So now to review the findings that we talked about last meeting regarding physician and other health professional services, first I'll start with access, and as we discussed last month, we surveyed -- our first point was that we surveyed over 8,000 people, which included an oversample of African Americans, Hispanics, and Asian Americans. And half of the people in this survey were Medicare beneficiaries age 65 and over, and the other half were privately insured people age 50 to 64.

We found that most Medicare beneficiaries are able to get timely appointments and find a new physician when they need one. We also found that Medicare beneficiaries reported better access than their privately insured counterparts. Medicare beneficiaries continue to be less likely to forgo care compared to privately insured individuals.

I'll note here that, at Mitra's request, we tried

to add some more details about forgoing care, but it really is small cell sizes, and we try to be as specific as we can, but still having credibility about the numbers that we produce. So I would still want to say that Medicare beneficiaries were less likely to forgo care, and we did find that the private insurance groups seemed more sensitive to costs. They said that one of the reasons that they didn't forgo care was cost more often than Medicare beneficiaries who did forgo care.

Then referring now to these last two bullets on the slide, we see that needing to find a new physician, particularly a primary care physician, is really quite uncommon. Specifically, only 7 percent of Medicare beneficiaries and, the same percent, 7 percent of privately insured people said that they had occasion to look for a new primary care physician. So one could argue that that suggests that people are generally satisfied with the current primary care physician that they have.

Now, of course, we indicated the problems that people are facing when they're in that situation, but it's important to keep in mind that it's a small population that were even looking. But as I said, for primary care

physicians that was more difficult, the survey respondents indicated, than finding a specialist. So finding a specialist when you had to was a bit easier.

Another specialty that you all raised during last month's discussion was about psychiatrists, and that was discussed as one of the specialties that has had difficulty for finding referrals for Medicare patients in particular. And I want to mention that last year when we had focus groups with physicians, that was raised then as well, and so we've reiterated that in the chapter draft that you have before you, that psychiatrists have been mentioned and highlighted as a difficult referral source.

Moving on, from the oversample of minorities in our survey, as we discussed last meeting, we continue to see that minorities in both insurance groups experience more access problems than whites. Keep in mind, however, that Medicare minorities reported better access compared with privately insured minorities. That means the discrepancy was a bit narrower for Medicare beneficiaries, and on the whole, their report of access problems was lower.

With respect to rural beneficiaries, we find consistently that rural Medicare patients reported better

access compared with their rural privately insured counterparts. So when you're just looking in rural areas, you again find that Medicare beneficiaries in rural areas report better access than the privately insured ones. But if you're only looking at Medicare beneficiaries, we found that those in rural areas were a little more likely to report problems scheduling a timely routine care appointment. But in finding a new primary care physician, they had an easier time than urban beneficiaries. These differences are very small, though, I want to reiterate, but it does show you that there's a bit of a mixed picture there, and we look at it both within just Medicare urban and rural and then comparing Medicare to private.

Moving on here, we also, as we talked about last time, looked at other national patient surveys and found analogous results to our survey. I reviewed this list last month, but I'm just going to mention one item that Mary brought up, and that's about the Commonwealth Fund survey. That's the third major bullet there. That was a survey that inquires about access to "medical care from a doctor or other medical health professional." That's the exact definition used there. And I think that perhaps for next

year's MedPAC survey we should consider using that kind of a definition and perhaps probing a little bit more about primary care and who the patients are receiving -- many times, you know, there are more questions that come out of changing the survey when you get the results, but I think that this is a really good thing that we should be pursuing, and maybe we'll talk more as we work on that survey.

This slide lists other physician surveys that we also reviewed, and I'm just going to raise a point because there were some questions about whether these results distinguished between acceptance of all or some patients and whether these surveys are asking about new Medicare beneficiaries and not just established patients.

So in response, I just want to note that the NAMCS and the HSC survey do refer to new patients, and I want to make that clear. But the HSC survey further distinguishes between acceptance of all, some, most, or none.

Just to put a data point out there, that survey found that 74 percent of Medicare physicians accepted all or most new Medicare patients. It also found that practices that were most likely to accept new Medicare patients were those that were specialists, in rural areas, new physicians,

and those in group practices.

And then that sort of leads us to this next survey that I didn't really highlight last time, and this is a survey that the Medical Group Management Association released, or at least they released the results, and it found that 92 percent of medical group practices accept new Medicare patients; 7 percent take only those that are established patients that age into Medicare; and then 1 percent do not accept any Medicare patients.

Next slide. This is a quality slide that we went over last time, and it's on ambulatory quality measures. It's a claims-based survey across the U.S., the whole national population. And it found that 35 out of 38 of the indicators improved slightly or were stable during these two comparison years. And among the three that declined, the differences were small but statistically significant.

Now Kevin is going to keep going with the analysis.

DR. HAYES: As we reported in December, Medicare claims data show that the volume of physician services continued to grow in 2009. We also noticed that at least since the year 2000, volume growth has been lower for major

procedures and evaluation and management services compared to imaging, tests, and other procedures. Yes, imaging growth has decelerated some in recent years, but it has remained positive after many years of rapid volume growth. Meanwhile, we have seen further increases recently in the growth rate for tests.

Before I leave that slide, let me just mention that at the December meeting Ron brought up the point about early data on volume growth in 2010. It is true that CMS actuaries have begun to use data on total spending for physician services for 2010 to do some of their preliminary calculations for the SGR. But we do not yet at this point have detailed claims data necessary to analyze growth in the volume of services in 2010, that would not be at the level of total services nor by type of service.

We can say that the CMS Office of the Actuary and others have been documenting a broad slowdown in national health care spending, a slowdown that has been attributed to the weak economy.

Now, on to the other indicators in this sector, the ones you saw last month, there was, first, the ratio of Medicare's payment rates to private PPO rates, and they had

remained stable. We also have continued high levels of participation rates and claims paid on assignment. And looking forward to 2012, the year for which you would make an update recommendation, CMS' preliminary forecast of the Medicare Economic Index was 0.7 percent. Since the mailout of the draft chapter, the forecast of the MEI for 2012 has gone up to 1.0 percent, and it will be re-estimated several more times between now and next year.

I keep getting ahead of myself here. We do you want to come back to this first bullet on this slide and remind you that Bob made an important point last month about performance-based payments and that those payments are not included in the claims data that we use to compare Medicare and PPO payment rates. We have started to look at this, and I can provide some more details if there are questions.

As discussed in December, stakeholders have expressed a concern that this sector's updates have been less than changes in input prices, whether those changes are measured by the MEI with or without a productivity adjustment. On the slide, the updates are represented by the lower line with the Xs; the MEI is the line with triangles; and the MEI without the productivity adjustment

is the line with the squares.

As we pointed out last month, however, the problem with such is that they do not consider volume growth and its effect on practitioner revenues. By contrast, spending growth includes growth in the volume of services. In the graph, the top line is growth in volume of service per -- or spending per beneficiary. And it's the updates plus the volume growth that bring about increases in practitioner revenues from Medicare.

Last month, we described, in addition to our work on the physician update, a study for the Commission by the Medical Group Management Association and the Urban Institute, a study that considered: first, the actual compensation received by physicians; and, second, compensation simulated as if all services were paid under Medicare's physician fee schedule. Based on data for 2007, actual compensation averaged across all specialties was about $273,000 per year. As expected, average simulated Medicare compensation was lower, at about $240,000.

Comparing specialties, we see disparities when we look at hourly compensation, a measure that accounts for differences among specialties in hours worked per week. The

disparities are largest when primary care is compared to nonsurgical, procedural specialties and, separately, radiology.

If we look instead at simulated hourly compensation, we see some narrowing of the disparities between primary care physicians and specialists, but it is minimal. In any case, these disparities raise concerns about equity and the future of the practitioner workforce. With that in mind, we are continuing to work on issues concerning the valuation of services in the physician fee schedule. You can expect to see more on this at future meetings.

Cristina will now present the draft update recommendation.

MS. BOCCUTI: So on to the chairman's draft recommendation for fee schedule services. The Congress should update payments for physician fee schedule services in 2012 by 1 percent. So a bit of background on this.

For 2010, the update was 0 percent from January to May, but 2.2 percent from June through December.

For 2011, this year, there was no update from where it left in 2010.

Then for next year -- that is, 2012, the year for which we are making a recommendation -- the SGR calls for at least a 25-percent cut and then another one in 2013.

The Commission has stated that it is not supportive of these multiple payment cuts. We've said that in past chapters. So given the array of factors that Kevin and I reviewed and we discussed in the draft, basically generally good access, stable quality, increasing volume, et cetera, and a need to be fiscally disciplined while maintaining access to physician and other health professional services. We have the proposed recommendation on the screen.

Regarding the implications of this recommendation, the spending effects are, of course, large because any increase would be scored relative to the deep cuts that the SGR calls for in current law. So that's why you're looking at this spending bucket, and maybe I should mention for all the future update discussions you're going to have, these are spending buckets that we discussed with CBO, where we're not getting a specific point estimate, and it's not MedPAC's role essentially to make these point estimates. But we do talk with CBO and say does it fit into a low spending

bucket, a medium? And so the parameters you'll see that we have on this screen, this is the highest bucket to be clear. But you'll see other sort of buckets where you have a range. And Glenn might want to talk about that more, but for the audience and for the Commissioners here, that's where we come to this spending implication.

And then the other beneficiary and provider implications, we see that there would be an increase in beneficiary cost sharing and premiums certainly relative to what the SGR is calling for, but I want to reiterate that the increases would be in line with what has been happening in previous years, because it's an update that is in line with what has been going on in previous years.

Then the final bullet is that this update recommendation would continue to maintain physician and other health professional acceptance of Medicare beneficiaries.

There is one more slide we want to make sure we leave you with, and that is about the issues that I mentioned at the beginning of the presentation. So this is about the commitment from the Commission to continue working on ways to enhance access to primary care, exploring other

levers, and to continue examining the SGR payment policies. Again, we talked about the mounting frustration and the looming cuts that are creating some of these anxieties, and to look again at advantages of expenditure, target approaches, but minimizing those that we see in the current system.

MR. HACKBARTH: Thanks, Cristina and Kevin. Thank you, Cristina, for explaining the spending effects, and let me ask you just to go a little bit further. If you would, put that slide up for a second. Could you describe for the audience what the buckets are? I don't want people to look at this slide and see, say, $10 billion over five years and think, oh, that means it's $10.1 billion. When it's over, that means it's just over a boundary. So could you just describe the buckets in a little bit more detail?

MS. BOCCUTI: Sure. I don't know the exact parameters of each bucket. I'm going to say this, but Shinobu might be able to help me. She's our liaison in this regard. I think the first one is $250 million. Is that -- maybe you could grab a microphone, Shinobu.

DR. MARK MILLER: She can come to this one.

MS. BOCCUTI: She's really the one that's --

MR. HACKBARTH: Great.

MS. BOCCUTI: And then I'll talk about the physician one that you mentioned, Glenn.

MR. HACKBARTH: Yes.

DR. MARK MILLER: And since Shinobu is bashful, she's making me do it.

[Laughter.]

DR. MARK MILLER: This will be dealt with later.

[Laughter.]

DR. MARK MILLER: The buckets actually go down -- I'm just kidding, okay? The buckets go down further than that. We have a bucket as low as "less than 50 million," 50 to 250, 250 to 750, 750 to 2 billion, greater than 2 billion. That's the one-year buckets. But that's just -- and then there's a set of five-year buckets. So we have these categories. We worked the categories out with CBO in sort of ranges, and as Cristina said, we just basically interact with them to say, is this roughly the right bucket that it goes in.

MR. HACKBARTH: And the reason that we use buckets is not to be evasive and obscure, but our mission is not to do budget estimates. That's CBO's responsibility. Having

said that, CBO has a lot of things to do other than just work on our estimates, so we have this process whereby we have these informal conversations that are precise enough to get it in a bucket but not asking CBO to work on a point estimate as they would do for the Congress on a legislative proposal.

MS. BOCCUTI: So with your question, there shouldn't be a misperception that it's around $2 billion. It's more.

MR. HACKBARTH: Right.

MS. BOCCUTI: It is more, and I can -- we can read off the numbers from CBO, but I want to be clear. This is just above the biggest bucket. And again, the reason is that there are huge cuts and those cuts that are in the SGR that would happen in 2012, they would go on. They would continue. So if you had a 25, say -- and even the amount of the cut isn't specifically determined yet. We'll say it's upwards of 25 percent just for that year. Then the payments would continue -- would go down again the following year and continue to be low. So a one percent update this year, if that were to continue in that realm, the difference would be very large and that's why we're getting to these numbers

that may look large here, but they're even larger, and I think that's the point you wanted to make, Glenn.

MR. HACKBARTH: Exactly. Exactly. In just a minute, we will turn to our normal process of clarifying questions followed by a second round of comments, but I just want to make a few other observations before we begin that.

First of all, those of you in the audience who follow MEDPAC's work will realize Ron Castellanos is not here. Ron got caught up in the travel disruptions due to the snow and could not make it to the meeting, so that's a loss. On this particular topic, I know he's got a lot of feelings and things to say.

The second broad observation is that those of you who came to the December meeting will recognize that some of our recommendations have -- the draft recommendations have changed since the December meeting. This one has not, but others later in the day have changed, and the process we use is that we have the discussion at the December public meeting. I follow up that conversation with individual conversations with each of the Commissioners on the recommendations and we use the combination of the public discussion in December and the one-on-one conversations to

refine the package that will be presented over the next couple days.

A third broad observation that's illustrated by this recommendation is that all of our recommendations will be expressed as a number as opposed to a formula. So in some years past, we have expressed recommendations as marketbasket or marketbasket minus something, and in recent years, we've gradually evolved away from that and began, I think actually with physician services, expressing recommendations as a number as opposed to a formulaic statement. With this year's package of recommendations, we will have completed that process. All recommendations will be stated as a number as opposed to through a formulaic statement.

I want to be clear. The fact that we don't use marketbasket language in the recommendation does not mean that we don't take projected marketbasket increases into account in formulating the final recommendation. It's just that we're not expressing recommendations in that format any longer.

Then one last comment. At the December meeting, Cristina presented much the same -- in fact, the exact same

survey information that we collected on beneficiary satisfaction with access, and I tried to explain how that data could be accurate and reconciled with the fact that, for example, some members of Congress get a lot of complaints from constituents about having impaired access to services. And I want to try that again, because what I said was misinterpreted and misreported in December in a couple cases.

So we have these survey data that broadly show, as Cristina described, that access to services for Medicare beneficiaries is as good or perhaps even better than access to care for privately insured patients in the under-65 age group. And we show only a small number of patients reporting problems in finding a new physician. As Cristina described, we're talking about, first of all, a small percentage of Medicare patients having to look for a new primary care physician, and then a fraction of those saying that they're having a problem, a small problem or a big problem. When you do the math, you know, we're talking about a couple percent of Medicare beneficiaries saying that they're having a problem finding a new primary care physician. So that's what the data show.

And what I tried to do is explain how that might be consistent with a particular Congressional district experiencing a lot of phone calls and a lot of letters complaining, and I think there are two ways that you might reconcile those numbers. One is that our survey information is national survey data and there is variability in markets. In some markets, access for Medicare beneficiaries may be more problematic than in other markets. It's important to keep in mind that the problem areas, where they exist, it may have nothing to do with Medicare payment rates but have something to do with what's going on in the market overall and access to care, to primary care physicians. Too few primary care physicians in general for all patients of all types, shifts in the demographics of the population. There are a lot of things that could go into making an acute access problem in a particular area. So that's one reason that a particular member of Congress might be getting a lot of complaints and seem like our data are too optimistic, if you will.

The second point that's worth keeping in mind, that even if it's only a couple percent of Medicare beneficiaries experiencing problems finding a new physician,

that's a lot of people. Two percent is, you know, like 900,000 people, approaching a million Medicare beneficiaries. And you work that out on a per Congressional district basis, that's still a lot of people who could be experiencing significant problems -- severe problems that we need to worry about. But that -- it's still consistent with our overall national survey result.

So I just want to be really clear. There were some reports that I said that I didn't think our survey results were accurate. That's not what I'm saying. I do think our survey results are accurate, but I'm trying to explain how they can be accurate and there still be significant problems that Medicare patients are experiencing and a significant amount of mail coming into a Congressional office. I don't think there's an inherent conflict in those data points.

So I will shut up for a while now and we will begin round one clarifying questions with Karen.

DR. BORMAN: On the SGR conversation, can we easily break out the proportion that is really the result of fixes that weren't paid for, you know, that were paid for to the future and so that they add artificially to the total --

the cumulative number of the SGR as opposed to the parts that relate to true, if you will, excess utilization above the estimates? Do we have a, even a feel for sort of what percentage of it is driven by that, sort of Congress-made fixes that said --

MS. BOCCUTI: So you're sort of saying the effects of sort of the compounding component --

DR. BORMAN: Right, a little bit, and --

MS. BOCCUTI: Let me think about that --

DR. BORMAN: -- part of it is really due to physician practice versus that's due to sort of just the budget calculation. It doesn't particularly affect the update this year, but as we continue, as we say in our goal to continue to look at the SGR and other frameworks, that perhaps it would be helpful for us to have at least an idea of what relates to what.

MS. BOCCUTI: Let's think about what's possible.

DR. BORMAN: Thanks.

MR. HACKBARTH: Round one clarifying questions. George and then Herb.

MR. GEORGE MILLER: Thank you. On Slide 6, please, we're talking about access with minorities. This

slide, just talking in general, can you break down for specialists, because in the reading it seems to me that there was more of a problem with minorities getting access to specialists than primary care. Could you talk a little bit more about that, and then what potentially would be the levers to solve that if there could be in your research? I read a couple things here in the --

MS. BOCCUTI: Well, I'm looking at that chart. I guess there's on page 14 -

MR. GEORGE MILLER: That's what I have.

MS. BOCCUTI: -- and I assume -- yes. We did not dig deeper into finding that result, but that's something that we can look into a little bit more in future work. I'm not sure we'll be able to include that in this work --

MR. GEORGE MILLER: Right.

MS. BOCCUTI: -- but maybe there are some other studies that I could try a little harder to look at and see if there are some findings there about specialists and access by race and another demographics.

MR. GEORGE MILLER: Yes. That's the problem that's troubling with me, because if the majority -- if a specialist is available for one segment of the population,

but not for another, that's troubling to me and that's why I want to use that specific issue. Both have Medicare. Both live in the same community. But minorities are not getting to specialists the same rate as whites, and that's just a problem for me. All right. Thank you.

MR. KUHN: If I could look at the chart on page ten, and I'm curious about the lines of growth and particularly just want to ask maybe Kevin a question on imaging. We know we had significant growth rates in the first half of the decade. It slowed a little bit in the second half of the decade. I think mostly the policy lever was a DRA, which slowed it dramatically. But I guess some of the data I've seen recently or have heard about recently seems to indicate that imaging is -- the growth rate in imaging is pretty much flat or at least some modalities it is actually decreasing. Is that, in a sense, what we're seeing from the claims data right now, or do we still see imaging continuing to increase?

DR. HAYES: The overall growth rate for imaging, 2008 to 2009, was two percent. But we did see some declines within that general category. You know, they had to do with one category of MRI, nuclear medicine, that kind of thing.

Is that what you mean?

MR. KUHN: Yes. That's correct. So that we are -- that's consistent with what I'm seeing, and so I just couldn't tell from this chart if that's kind of what we were seeing, as well, and that sounds like it's consistent, then, so thank you.

DR. HAYES: Yes.

DR. BERENSON: Yes. I want to follow up on Herb's question. In the chapter you gave us, you made the point that the volume growth data can be affected by changes in site of care. And in the discussion on hospitals, there's a discussion about hospital acquisition of physician practices. So I want to sort of understand what that phenomenon does to the volume growth. Am I right to say that the impact would be on practice expenses, that physicians who are now provider-based and building as part of a hospital would no longer get their practice expense? In the Physician Fee Schedule, there would be a separate payment to a facility. Their work wouldn't be any different. So I guess, I mean, one, is that correct, and two, then is there a downward -- is there a bias under-reporting volume growth in the Physician Fee Schedule

because of this shift if it's mostly going in that direction and is accelerating?

DR. HAYES: Yes. It is true that the way the payment would work, the physician would continue to bill for the professional component of the service and that that would still appear as a fee schedule payment, but that payment for, as you put it, the practice expense component would shift from payment under the fee schedule to payment under the outpatient prospective payment system.

MR. HACKBARTH: This is a volume count. This isn't dollars.

DR. HAYES: Correct.

MR. HACKBARTH: So if this is just a volume count, that wouldn't affect these numbers, right, because you would still have a bill for the professional component that would go into the volume count.

DR. HAYES: You would still have a bill, but it would be -- the shift of practice expense out of the fee schedule would, in a sense, represent a change in the intensity of the service. Recall that the term "volume" as we use it includes both number of services and the intensity of the service, the RVU associated with a service. And so

the RVU for a service payment would go down because we have payment for the professional component but not for practice expenses.

MR. HACKBARTH: So that's helpful. So this is a volume and intensity graph?

DR. HAYES: Correct.

MR. HACKBARTH: Because as I recall, in our table in the chapter, we present both the volume column and a volume and intensity column. This is actually volume and intensity.

DR. HAYES: Correct.

MR. HACKBARTH: Okay.

DR. MARK MILLER: And I think his statement is true about if you were just counting the services.

MS. BOCCUTI: Units.

DR. HAYES: Yes.

DR. MARK MILLER: The units, the first section of the table that's in the chapter. But the second section on volume intensity, which is reflected here, would be affected by the point that Bob is making.

DR. HAYES: Yes. Yes.

DR. BERENSON: And so if I could just finish up,

to follow up Herb specifically, would we be able to calculate sort of for imaging, because some of the -- and what we're aware of apparently is cardiologists in particular who had been doing a lot of nuclear studies and other services in their offices are one of the specialties that are now being acquired by hospitals, and so imaging might be falsely low, I think. Are we able to calculate sort of, make an adjustment for the shift in site of service to actually get a different number for volume growth for imaging, for example?

DR. HAYES: What we could do is look at volume growth by place of service, right, and so we would -- you would expect to see, then, fewer services billed from a, quote, "office setting" and more services billed from a facility setting.

DR. MARK MILLER: Bob, I think when we get to the OPD, ASC, and hospital presentations, there's been a specific attempt to try and parse -- right. Okay. Good enough.

DR. NAYLOR: So, Cristina, Kevin, thanks so much for a great chapter and for responsiveness to so many of the comments from last month's meeting. I do have, on Slide 25,

two questions, and this relates specifically to the recommendation.

DR. HAYES: What was that slide number again?

DR. NAYLOR: Oh, I'm sorry. I'm dyslexic. Fifteen.

[Laughter.]

DR. NAYLOR: I'm moving ahead faster than we should, right?

[Laughter.]

DR. NAYLOR: So I wanted to know if the recommendation explicitly should read that should update payments for hospital and other health professional services, and let me just comment on that, that the Affordable Care Act and IOM have stimulated use of nurse practitioners in primary care practices, so where in 2009 ten percent of Medicare spending accounts for spending by -- or direct reimbursement to those NPs and PTs, it might grow by 2012. So I wanted to know, does this payment schedule recommendation include all health professionals and should we state that?

MS. BOCCUTI: Yes. We'll make sure we make this clear. That's a very good point. But technically speaking,

it's still called the Physician Fee Schedule --

DR. NAYLOR: Okay.

MS. BOCCUTI: -- and that's what these Part B payments are coming off of. It's the list of 7,000 services and it is not specific to who bills them. It's who can possibly bill them, which includes these other practitioners. And so whether it's a physical therapist or a nurse practitioner, they're billing off of what's called the Physician Fee Schedule. And so what's different here, then, I'll mention, and for this very reason, it doesn't say physician services. It says Physician Fee Schedule services to address that, as well. And I think maybe what we'll do is we'll make it really clear that multiple health professionals bill off of that Physician Fee Schedule and this applies to them.

DR. NAYLOR: Terrific.

MS. BOCCUTI: Is that --

DR. NAYLOR: Yes, that's great.

MS. BOCCUTI: Okay.

DR. NAYLOR: And the second has to do with the spending implication. If we were to see a shift in the providers of primary care in 2012 that's expected as a

result of the IOM recommendations around opening scopes of practice, et cetera, have we modeled what that shift might look like? You know, NPs in the Physician Fee Schedule are reimbursed at 85 percent of the physicians, et cetera. So have we modeled what a changing dynamic might look like in the primary care provider workforce in terms of spending implications?

MS. BOCCUTI: Well, this is really about this recommendation. In terms of modeling that, again, this sort of falls into a discussion that we have with CBO about what bucket this would fit. And so perhaps in those discussions, we'll raise that issue and see. But we are not modeling specifically the projection, but I hear what you're saying.

MR. HACKBARTH: So perhaps what we could do is -- my hunch is that that effect, however important, is not large enough to change the bucket location of this number because we are so far over the boundaries --

MS. BOCCUTI: Right.

MR. HACKBARTH: -- but we could say in the text that to the extent that there was such a shift over time, it would affect spending under the Physician Fee Schedule.

MS. BOCCUTI: Mm-hmm. And to be clear, this

workforce question, there are a lot of nurse practitioners and other health professionals who are providing the services, but it's billed because the physician is supervising them. So there's that 85 percent rule that you're talking about and that's about directly billing, you're right. But then there's other. There is going to be more workforce, as you said, and it doesn't mean that it would be affected because of the way it's billed.

DR. NAYLOR: So I absolutely agree, but we have now several States opened their scope of practice to get direct billing --

MS. BOCCUTI: Right.

DR. NAYLOR: -- so it could.

MS. BOCCUTI: Right.

DR. NAYLOR: And I'm just --

MS. BOCCUTI: Absolutely.

DR. MARK MILLER: I almost see this, and I know you're not saying this, but I almost see your question as different, which is what are the implications of the recent changes in the legislation and the opening up of the State practices to supply utilization. I'm almost viewing it as separate from what we happen to be doing here today, and I'm

sort of viewing your question more broadly for us to think about as we go down. Not to change what you're saying, but I see almost a bigger issue behind what you're asking.

MR. HACKBARTH: Okay. Round one clarifying questions. Mitra, Peter, and Mike.

MS. BEHROOZI: Thanks very much for putting in the additional textural stuff about people forgoing care.

A couple of questions about the survey. The privately insured individuals, we kind of know what private insurance looks like or is about. But with respect to the Medicare beneficiaries, do we ask if they have Medigap coverage, if they have supplemental coverage, and do we know whether they are dual eligibles, and would the survey include dual eligibles?

MS. BOCCUTI: Regarding other insurance, we've tried hard. We've tried to see if they're in an MA plan and that is just -- in order to get this survey done, to get it the most timely, to get it out there to be the year that months ago they were being asked, if we can get that survey, it needs to be relatively short and it's conducted primarily on the phone. We have not found reliable results on questions about other insurance. We can really just parse

through Medicare. So we can't talk about supplemental and other insurance.

I do not think -- we do not disqualify someone if they're dual, if they also have Medicaid. But if they don't have Medicare and they do have Medicaid, so if they're the under-65, they're not included.

MS. BEHROOZI: So when you refer to the lowest-income people and what they report about forgoing care, that could include duals, as well. It's not like the lowest income above the dual eligibility level or something like that --

MS. BOCCUTI: Absolutely. Of the Medicare, right.

MS. BEHROOZI: Right.

MS. BOCCUTI: Absolutely.

MS. BEHROOZI: Okay.

MR. BUTLER: So the purposes of us looking at access is to inform the payment update to make sure we have enough doctors and timely appointments. So on page seven, or Slide 7, I'm just trying to clarify who we're serving. The first one, these are the other surveys, so it's pretty clear the CAHPS one is the fee-for-service population, because that's who we're really talking about here. Are all

the previous results that you have related specifically and only to the fee-for-service enrollees?

MS. BOCCUTI: No. Like I was saying with Mitra, we have not been able to parse specifically fee-for-service. So there are MA patients in that survey. But this CAHPS survey, which is much larger, does -- and they can start from knowing what -- it's from CMS, so they know what the patient has when the survey is sent out to them. So that's how they're able to distinguish exactly what insurance they're under, MA or traditional Medicare.

MR. HACKBARTH: The reason for combining the MA and the Medicare fee-for-service is that we have found through testing that Medicare beneficiaries doesn't accurately consistently distinguish between, oh, I'm traditional Medicare versus Medicare Advantage plan members.

MS. BOCCUTI: Or prescription drug plan, and that made it more confusing, too.

MR. HACKBARTH: And so the errors in their self-classification just seemed too great to try to do that, that cut.

MR. BUTLER: So I know we're talking more about the MA plans tomorrow --

MR. HACKBARTH: Yes.

MR. BUTLER: -- and this issue will come up again, but it will, as we increasingly bundle, whether it's episode or ACO level, this question will even become more relevant in terms of the access issue, I think.

DR. CHERNEW: Can you go to the recommendation slide, which I think now is 15? When you get to the five-year projection, that assumes that the 2012 recommendation doesn't affect the SGR amount. So I could have thought about this a different way, which is you have a 2012 one percent increase like the recommendation says, but that would, with no change in the -- if I understand correctly -- this is why it's a question -- what that would do is that would make the SGR hole just a ton bigger in 2013, and then the five-year implication, if the SGR was still in force, would actually be it wouldn't cost us anything. So how should I think about the recommendation vis-a-vis the spending vis-a-vis the SGR?

DR. MARK MILLER: Well, do you want me to answer? Yes, the sort of stunned silence. And you guys need to help me out here.

First of all, I just want to say this.

Particularly as we go through these buckets and we look at this number -- this is more editorial before answering your question -- this one, it's relevance to reality, and I'm using that term very loosely, is very tentative, because, I mean, the assumption here is the baseline drops dramatically and stays down, and then this is saying, well, if you give this moderate one percent update, you have to fill all that difference and it's billions of dollars. And so this is predicated on the assumption that that happens, and, of course, year after year, that hasn't been happening. So the first point is it has a tentative hold on reality.

Your second, more directly to your question, it is true that with no change in the SGR, eventually, the SGR pulls it all back. So any increase you give over some period of time, it gets pulled back, and that length of time is made longer by the fact that you forgave it for one year and gave an --

DR. MARK MILLER: [Off microphone.] Or makes it bigger --

DR. CHERNEW: It makes it bigger, and that's what -- I'm trying to say the same thing. You have to add a longer time to take back. However, what I don't think is

true is you get it back in five years. I think it still costs in the five-year window. You dig it out over a much longer period of time. That's the last sentence that I'm less comfortable with.

MS. BOCCUTI: Well, what I have here, because everybody can download this, these are the CBO's projections from, I think, April 2010, and so just for a one-year -- now they have it for 2011 because this happened last year. But just to put this out there, for a one-year, if it was an MEI update for just one year and then the, we could call it cliff, that's what's written here -- I didn't make that word up -- if the drop were allowed to go, just the one year is almost $9.5 billion. And then the next year there would be a drop, too.

Now, that means that your five-year projection includes that amount, but then it will be collected. Of course, the updates will be dramatically lower. So it's always going to be in your five-year and ten-year window because you spent that. You spent that in that year and you spent it in the next year.

MR. HACKBARTH: What you're saying, Cristina, if I understand you correctly, is that the first year effect is

large enough to put us into the five-year --

MS. BOCCUTI: Exactly.

MR. HACKBARTH: -- in the five-year bucket --

MS. BOCCUTI: Right.

MR. HACKBARTH: -- even if you assume it's all taken back --

MS. BOCCUTI: And there's no --

MR. HACKBARTH: -- you still have the one-year cost.

MS. BOCCUTI: Right.

DR. CHERNEW: So just to clarify my clarifying question, our assumption is really just a one-year assumption with no assumption about any change to the SGR, so eventually, it might not be even the five-year window, but eventually, the fiscal ramifications of this would be essentially none because we're not changing the SGR --

MS. BOCCUTI: Right.

DR. CHERNEW: -- but we would have a big increase now and not one later.

MS. BOCCUTI: Right. If there was a cut, there would be zeroes in those years, individual years later on. But that's exactly right. This is not an SGR

recommendation. It's a one-year recommendation and the costs are beyond our biggest bucket.

DR. CHERNEW: Right. Despite --

MS. BOCCUTI: If we could write --

DR. CHERNEW: -- the SGR is still going to take it back.

MS. BOCCUTI: Right. Right. Right, because you had to spend it.

DR. BAICKER: So just to make sure I got that, there are two different ways you could score this -- not that we do scoring -- sort of dynamically where it feeds back into the SGR and that updates over time, or statically where you pretend the baseline is the SGR as if this didn't happen. Those two would give you different numbers, but both of them are so big that they're in the same bucket, so we're not trying to distinguish them.

MS. BOCCUTI: Yes.

MR. HACKBARTH: Okay. We've made it to round two.

[Laughter.]

MR. HACKBARTH: So round two comments, and we are woefully behind, so please be as crisp as possible. Karen and then Scott.

DR. BORMAN: First, let me say I support the recommendation as it lists there. I think that it's appropriate, given the pressures on physician and other appropriately licensed health care professionals providing services under the fee schedule at this point in time for all the reasons that are nicely outlined in the chapter. And I particularly appreciate the Commission as a whole being supportive of the concerns for the beneficiaries and the physicians and other professionals that they utilize by virtue of these short-term fixes.

Just a couple of things that I would say, and wouldn't necessarily relate to this recommendation or this chapter, but as we continue to go forward, I hope that we will continue to -- in consideration of what a multi-disciplinary or a multi-level workforce looks like, that we continue to use language that helps us differentiate when we're delivering primary care services, which can be delivered by a variety of practitioners, versus perhaps things that are uniquely primary care physician services that we need to be quite careful on that, and on an analytic basis that we continue to explore when should we start parsing out some of those pieces of the data and which ones

might be relevant to future considerations, because there will be, you know, the question that Mary raised about modeling may, in fact, now be a very small piece of the puzzle, but I think as we think about workforce in general terms and what it should look like and what the implications of that are, that the very bright analytic staff that we have will come up with much better questions and thoughts about that than I ever could. But I think we should keep that in mind.

And then one other thing I might suggest at some -- not necessarily in the current landscape chapter, but perhaps at some future time -- is we have taken a number of steps to try and enhance primary care rewards over the past several years. Certainly the 2007 five-year review of physician services resulted in a major redistribution. The practice expense new formula did some similar things. So perhaps a text box at some point that outlines all the moves that have been made so that we can consider what might or might not be appropriate in the future based on what we have already done, I think might be a helpful reminder for us and hopefully for our audience at the Congress and their staffs, where some of that stuff gets lost in the turnover that goes

on in the legislative branch.

MR. ARMSTRONG: Glenn, I, too, support the recommendations. The one point I wanted to make, actually building on several comments made about this upcoming study regarding primary care or regarding access more broadly, in addition to the points just made, I would also just say that we've seen and we've had our own experience dramatically increasing access that's valuable, that's useful, that's effective access, not just through non-physician providers but through kinds of access that don't presume you're sitting in an exam room being seen by a provider. Whether it's through e-mail contact or telephone calls or group visits, there are so many other ways in which you can dramatically improve effective access. My hope would be our study includes that kind of evaluation, as well.

DR. STUART: I also support the recommendation. I'd like to respond to a point that Peter raised, if you could go back to Slide 7, please. That's too far back.

[Laughter.]

DR. STUART: Seven. The MCBS does contain administrative indicators of whether the person is in fee-for-service or in an MA plan, and so it would be possible to

look at individuals who are in fee-for-service to determine whether they had differential issues with respect to access as opposed to those in MA plans. So the question is, were the numbers that you represented here and in the text of the chapter restricted to the fee-for-service population in MCBS or did they cover everybody?

MS. BOCCUTI: With the MCBS, I don't think I deleted those that had MA. So that's a very good point. Let me look at that. I mean, it's a bullet point in the chapter, but I just -- I did non-institutionalized, but that's a good point, to make sure we're looking at fee-for-service.

DR. STUART: And I think it also might be useful just in a footnote just to indicate how they differ in MA plans, where you would expect much lower problems with access, but so that we could focus on an answer to your question.

MS. BOCCUTI: Was there another one, or just MCBS that you're asking about?

DR. STUART: [Off microphone.]

MS. BOCCUTI: Okay. Okay.

MR. HACKBARTH: That's a good point. A challenge

within MCBS in terms of our needs is the lag, the time lag, and that's why we do the phone survey. But by doing it, we've got some limitations.

DR. STUART: Two-thousand-and-eight, and it does allow you to make that comparison.

DR. MARK MILLER: Can I do a real quick commercial, also just heads up for tomorrow. In the MA session, there will be some discussion of data between MA and fee-for-service, so just -- I know you're excited. Something to look forward to.

DR. KANE: Yes. I mean, I support the one percent. I guess at some point, it would be nice to have the discussion not couched in comparing it to this "when pigs start to fly" context --

[Laughter.]

DR. KANE: -- of the SGR actually being imposed, and I think there can be some more reasonable metrics that we should be looking at. I'm sorry. My husband has been playing "Angry Birds." I don't know if you all know that game, but they're flying at pigs.

[Laughter.]

DR. KANE: But I do think it would be useful in

the future -- I won't be here to look at this, but I would like to see other types of things to compare it to. For instance, how much are the private sector fees going up and what's the context of private sector fees? And, for instance, what's the impact on the beneficiaries paying the Part B premium, particularly those who actually have to pay the premium increases rather than the 75 percent who have been held harmless? I think that's more meaningful for me than this SGR stuff and I think we just end up getting totally distracted by what does this mean relative to the SGR, but there's much more meaningful things to be thinking about. I mean, physician income relative to the income of the population, or how fast is physician income going up relative to the income of the population. Those would be, to me, would generate a much more meaningful discussion of what's the right amount to raise this.

So as I say, I think the one percent, given the sensitivity and the frustration that providers are feeling and the concerns that we want to maintain access and we don't really know quite what's happening out there, those are all very important reasons to support the one percent. But I don't feel the "when pigs can fly" context is the

right one and I'd like us to start thinking about how to change that, even though there is this SGR out there.

MR. HACKBARTH: Good point. On the one issue of how quickly private fees are going up, I think we can infer that the rate of increase is similar to Medicare's because our ratio of Medicare to private payments is pretty stable.

George?

MR. GEORGE MILLER: Yes. Just to follow up, and this question came to my mind when Bob was talking about the questions of where fees are applicable with physician practices being bought by hospitals, my question is do we have a feel of the impact or how many physicians are selling to hospitals? Do we have scientific numbers or evidence? And this may be a better question in some of the other chapters, but do we have that now in this analysis and why they may be selling? It could be because of the uncertainty of the SGR, or do we have a feel for that at all?

DR. MARK MILLER: More of what we have, and you're going to see this starting in the next session and then in the session following that, more of what we have is less how many physicians are selling practices and why. We don't have a lot of information on that. What we're looking at is

looking at the trends and the volume in the different locations and kind of inferring what seems to be happening. And both in the ASC presentation and in the physician -- or, sorry, hospital presentation, this is going to get teased out a little bit more and it relates a little bit to what Bob was saying.

MR. GEORGE MILLER: I will wait until then.

DR. MARK MILLER: But actually, physician practices and why, not so much on that, just sort of the end result --

MR. HACKBARTH: But there are -- in fact, Bob, you have done some market work where you've interviewed people about these trends. So there's anecdotal information, but I'm not sure that there is --

DR. BERENSON: I'd like to say it's more than anecdotal. We call it qualitative research --

[Laughter.]

MR. HACKBARTH: Qualitative research.

DR. BERENSON: -- where I come from. No, Health System Change --

MR. HACKBARTH: We lawyers call it anecdotal, but --

[Laughter.]

DR. BERENSON: No. Health System Change has just completed its seventh round of site visits. I was one of the people who made site visits and I'm pretty confident we'll be writing a paper on our findings in the relatively near future about all the reasons that physicians and hospitals are getting together and reasons why in some cases they're not getting together. So our research will be published later this year.

MR. HACKBARTH: [Off microphone.] Round two.

DR. BERENSON: One, I support the recommendation. I just wanted to pick up on Bruce's good suggestion about using the MCBS to try to see if there's any differential between MA and fee-for-service. It's interesting, Bruce. Your hypothesis was that there would be less of a problem in MA and that's possible, but we saw that for this 50 to 64 population, there was more of a problem in commercial insurers. So if, in fact, there's less of a problem in MA, it may have something to do with network adequacy requirements or something in MA. So it would be very important to understand if there is a difference, so I endorse that suggestion.

MS. UCCELLO: Just quickly, I want to -- for all of these, I just want to be on the record for supporting using this zero as our starting point and then also reiterate that it's the end point that matters when we're comparing. And then I support this recommendation.

DR. NAYLOR: I support the recommendation with the clarifications and also because I'm persuaded that beneficiaries' access to services will not at all suffer as a result of this recommendation.

DR. DEAN: I support the recommendation with some hesitation, partly just because we have such a, I don't know what the right word is, distorted distribution system that this update goes into that I -- part of me says that any money we put in it just makes our problem worse rather than better. But I would wholeheartedly support what Scott said, that we really -- and in that context, what you said, Glenn, about payment reform recommendations, I think are way more important than anything we do here. And so this, in fact, is probably a relatively small issue. The payment reform issues are so much more important. And to follow on with that, I really appreciate what was said emphasizing the importance of enhancing primary care and dealing with SGR

and all those things. We really need to look at new payment structures, new models of delivery and all those things if we're really going to make efficient use of Medicare resources.

MS. HANSEN: I support the recommendation. I also appreciate, frankly, the various parts that have been brought up, but I want to underscore, and it probably is relative to the study that you're going to be coming out with, the thing that -- I attended a medical specialty group meeting and noticed the trending, that in a very short period of time, for example, cardiologists, about 80 percent may be somehow connected to an employment situation rather than in individual practices. So it's a trending, and found that the family practice folks are beginning to move in that. So this will have impact on the other end that was brought up, but to be able to have a broader aspect to consider this as we move also to payment reform changes. So it's like we've got to note these organic shifts that are happening quickly in the marketplace, but they have implications about access and payment reform. So I really think that work that's coming up is going to be very important.

MR. HACKBARTH: We are ready to vote. So on the recommendation, would you put that up, please? All in favor of the recommendation, please raise your hands.

Opposed?

Abstentions?

Okay. Thank you very much.

Next is ambulatory surgical centers.

MR. WINTER: Good morning. We'll be reviewing some basic information about ASCs and our payment adequacy indicators, and also addressing some questions that were raised by commissioners at the December meeting. At that meeting, we talked about not making a recommendation for an update for ASCs for 2012. However, several commissioners asked to have a vote on a recommendation, and so we will be presenting a draft recommendation today.

So first, starting with some important facts about ASCs, Medicare paid ASCs $3.2 billion in 2009, an increase of about 5 percent per fee-for-service beneficiary from 2008, ASCs treated 3.3 million Medicare beneficiaries in 2009, and there were 5,260 Medicare-certified ASCs. In addition, about 90 percent of ASCs have some degree of physician ownership, and according to data from an MGMA

survey Medicare payments account for 17 percent of ASC revenue on average.

I'd like to spend a moment addressing questions that were raised at the last meeting.

Bruce asked us to clarify how the growth rate of HOPD services presented in the ASC chapter relates to the growth rate shown in the hospital chapter. In the hospital chapter, we show that all HOPD, all outpatient department services -- that is all surgical and all non-surgical -- grew by 4.3 percent per year from 2004 through 2009. In the ASC chapter, we break this growth rate down into two components -- surgical procedures that are covered in ASCs and all other HOPD services.

Surgical services covered in ASCs grew by 0.1 percent per year in outpatient departments from 2004 through 2009, and these services account for only 5.6 percent of total HOPD volume. Meanwhile, all other outpatient department services grew by 4.5 percent per year.

George asked us to explore further why Medicare beneficiaries who are African American are less likely to be treated in ASCs than outpatient departments. Some of this difference is related to the higher proportion of African

Americans who are eligible for both Medicare and Medicaid, which we call dual eligibles. Dual eligibles, regardless of their race, are less likely to be treated in ASCs, and there could be a couple of reasons for this.

First, there is evidence that physicians are less likely to refer their Medicaid patients to an ASC than their Medicare or commercial patients, and this comes from a study done by John Gabel and colleagues.

Second, a majority of state Medicaid programs don't pay the Medicare cost-sharing for dual eligibles if the Medicare rate, not counting the cost-sharing, exceeds the Medicaid rate, and this could make dual eligibles less financially attractive to ASCs.

Third, this could be influenced by decisions about ASCs about where to locate. For example, they may prefer to locate in areas that have more commercially insured individuals.

And finally, we've been hearing that some Medicaid programs do not cover services in ASCs, and we're trying to get some more information about this.

Another issue that came up was the market basket for ASC services. CMS currently uses the consumer price

index for all urban consumers to update ASC payments. The CPI-U includes a broad mix of goods and services and may not be a good proxy for ASC input costs. Ron and Nancy asked us to look at whether an alternative price index would more accurately measure changes in ASCs' input prices than the CPI-U.

In last year's report, we examined whether the hospital market basket or the practice expense component of the Medicare Economic Index would be an appropriate proxy for ASC costs. We used 2004 ASC cost data from a GAO survey to compare ASC expenses to hospital and physician practice costs. Although the GAO data were not sufficient for comparing each category of costs across settings, they did suggest that ASCs have a different cost structure than hospitals and physician offices. Given this finding, the Commission recommended that ASCs submit cost data to CMS which would decide whether to use an existing Medicare price index for ASCs or develop an ASC-specific price index.

This slide summarizes our findings on payment adequacy which we presented to you last month. Access to ASC services has been increasing as shown by the growth in the number of beneficiaries served as well as volume per

fee-for-service beneficiary, and there's also been an increase in the number of ASCs. Meanwhile, access to capital has been at least adequate. However, we lack data on cost and quality of ASC services, so we are not able to assess quality of care or to calculate a margin. And the Commission has previously recommended that ASCs be required to submit cost and quality data.

So this leads us to the following draft recommendation: The Congress should implement a 0.5 percent increase in payment rates for ASC services in calendar year 2012 concurrent with requiring ASCs to submit cost and quality data.

Our payment adequacy indicators suggest that a moderate update is warranted for 2012. Cost and quality data are important to help determine the adequacy of Medicare payments to ASCs, select an appropriate market basket for ASC services, and assess and reward ASC performance. Thus, our recommendation for a modest update is linked to a requirement that ASCs submit cost and quality data.

Here, we talk about the implications of the draft recommendation.

In regards to spending implications, under current law ASCs are scheduled to receive an update for 2012 that is equal to the increase in CPI-U minus multifactor productivity growth. Based on the current forecast of CPI-U and productivity growth, the update would be 0.8 percent. Thus, our draft recommendation of 0.5 percent would decrease federal spending by less than $50 million in the first year and less than $1 billion over 5 years.

In regards to beneficiary and provider impacts, because of the growth in the number of ASCs and the number of beneficiaries treated in ASCs, we don't anticipate that this recommendation would diminish beneficiaries' access to ASC services or providers' willingness or ability to furnish those services, and ASCs would incur some administrative costs to submit cost and quality data.

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

MR. HACKBARTH: Okay, round one clarifying questions beginning on this side.

Peter.

MR. BUTLER: If I can articulate this, one thing we really don't know is we looked at if we knew physician

ownership down to the individual surgeon and looked kind of a two-by-two matrix -- ownership in a surgery center, no ownership -- and then looked at where they do their cases -- in an outpatient hospital or a surgery center. So you could get, for example, a physician that didn't have ownership but in fact uses a surgery center frequently, versus. It would be an interesting way to display this, to see what the impact is of this.

I realize these are small dollars in terms of some of the other services, but that would be -- I don't think we've done that, right? We probably could.

MR. WINTER: Well, the difficulty is that we don't have data on physician ownership of ASCs or many other kinds of facilities. So --

MR. BUTLER: I thought in our disclosure recommendations and all those other things.

MR. WINTER: Yes.

MR. BUTLER: That's forthcoming, right?

MR. WINTER: We made the recommendation. Unfortunately, that part of that recommendation was not adopted, has not been adopted yet by Congress. PPACA did include some of our other recommendations on reporting on

financial relationships between physicians and drug and device manufacturers but not regards to physician ownership of ASCs and other facilities.

Some of this information is reported right now to CMS if physicians are partners in a facility or have an ownership share above a certain percentage, I believe, but those data are not publically available. And so we don't have the information to, with certainty, link physicians to ownership of an ASC.

Studies that have tried to look at this use a proxy measure for ASC ownership. So they at whether physicians who do at least 30 percent of their cases in an ASC, and they assume that they're owners, but they don't have definitive information.

MR. HACKBARTH: Round one clarifying questions?

MR. GEORGE MILLER: Yes, on slide -- well, I guess I'll start with Slide 3. And in the text, again I greatly appreciate staff breaking out the information concerning dual eligibles and African Americans. I'm still struggling with the fact that it seems that this is a growing segment, that patients seem to be happy, physicians seem to be happy. There's access to care, but again we have this large and

significant portion of the Medicare beneficiaries that are not getting that same service.

I'm struggling with the why. If a service is good for a patient, other than it seems to be, my words, financial, but even though you have the same assurance at not being used or not taking to where a physician ownership -- those are my words. Whereas, physician ownership. So it seems to be a financial issue, and if that's the case my question is why do we have a recommendation for an update.

I get and support the quality data information. I get and support getting cost data information, but I'm struggling with why an update. So maybe that's more of a statement than a question.

MR. HACKBARTH: I think that your point is a vital one, that so far as we can tell there does not seem to be the same type of access to this particular service. I don't think that's unique to ASCs. In fact, within various provider groups there are particular providers who adopt strategies to get the most profitable patients that they can, and they can be strategies related to location. They can be strategies related to what services are offered. There are a lot of ways to do it.

So the problem is an important one, and I fear a fairly pervasive one. I don't mean to tar all health care providers, but this is not, unfortunately, an uncommon problem. And then the issue, if I'm right about that observation, is how effective is a payment update as a tool for dealing with this pervasive and critical problem.

And I think if we were to say for ASCs we've got this issue and we've got to reduce the update, we ought to be reducing updates for almost all other provider categories as well because there are providers within the hospital world, within the physician world, within the SNF world who are also consciously using strategies to select profitable patients.

MR. GEORGE MILLER: They at least know that we're going to raise the question and hold them accountable.

MR. HACKBARTH: I think the question is not only appropriate. It's a vital question to raise, and the issue is what are the tools that we have at our disposal to address it.

Other round one clarifying questions or comments?

DR. BORMAN: Just a quick question to make sure I'm not going off on a tangent, interpreting. As we look at

what appears to be a regrouping and shuffling back toward a hospital environment for some of this. That would then assume that these less complex and presumably less unit-charge cases, procedures, events would be moving back to this hospital-based setting, so that the mix of the hospital would then on per average, the costs, at least in theory, might go down. Is that a true statement?

So that just let's assume the scenario that everything, that there were no more ASCs. Thus, just for the sake of argument say doomsday scenario, no more ASCs, where everything is moved back to an institutional setting. Okay?

That now the mix here is a much broader range of illness severity, extended procedure and so forth, that it might eventually lead to a rebasing or recalculating or changes in the formula relate. Some of that could be recouped through changing that formula based on the change in mix. Is that -- would that be a logical though progression from what you've outlined?

DR. ZABINSKI: It's a possibility. I think the only way to know is after the fact and see what shakes out.

DR. BORMAN: But it would result in a lowering of

the average, would lessen the average complexity of the hospital outpatient.

DR. ZABINSKI: To the extent, yeah, the ASC patients are less complex, then yes.

MR. HACKBARTH: The problem is that our payment method doesn't adjust for the difference in complexity, and so if they move and if all ASCs went away tomorrow and the mix of hospital outpatient department patients changed as a result, it wouldn't necessarily automatically happen that we would have a reduction in expenditures because the payment systems don't work that way.

DR. ZABINSKI: That means this is like sort of a budget neutrality requirement over time. I mean one could see a rejiggering of the relative payment amounts for different services in the hospital area. But as far as a reduction in overall spending, no.

MR. HACKBARTH: Round two comments?

Peter? Or, Mike, did you have your hand up?

Okay, Peter.

MR. BUTLER: A quick comment, in general, we worry about physician ownership because it often creates higher than desirable utilization. In this case, actually one of

the ironies is that I think the cheaper ambulatory surgery center is often due to physician ownership because they agree to standardize and do processes in a very different. So it's an interesting kind of dilemma that we're in.

DR. MARK MILLER: Now I'm going to make the point because the other supplement to that question is what happens to the volume, and if there's any induced volume that's the other calculation about, on net, what's the impact.

MS. BEHROOZI: Actually, that was the comment that I was going to make, that you note in the paper that over in the course of one year the volume per beneficiary with respect to the newly covered services rose by almost a quarter. So yeah, this opportunity seems to be, in addition, the opportunity to increase volume goes hand in hand with the opportunity to offset more expensive services elsewhere.

And I would state I will vote for the recommendation, but I would state more strongly even the requirement to submit cost and quality data. I mean if I had my druthers I'd say that they shouldn't get the update. The update should not be awarded unless the requirement for

cost and quality data is imposed.

DR. DEAN: Just to -- I would -- I do support the recommendation with some trepidation, mostly for the reasons that have already been stated. I'm concerned about the conflict of interest issues. I'm concerned about the issues that George has raised. And I'm also concerned about the fact that we're sort of almost flying blind because we really don't know what the costs are, we really don't know what the justification for an increase is. And so I'm hesitant.

You know, I think I can support it because obviously a half percent is not going to be a big issue, but I think all of those issues really needed to be stated and need to be emphasized. We've got a lot of serious questions here.

DR. NAYLOR: So I support the recommendation and would -- I don't know if there's an opportunity to strengthen it by stating that the increase, as stated earlier by others, is available only with submission of cost and quality data. I mean I thought that that was implicit in the recommendation, and maybe we need to make it much more explicit.

MR. HACKBARTH: Yeah, the language.

DR. NAYLOR: It says “concurrent with.”

MR. HACKBARTH: Yeah, the way I read this language is this is our recommendation to the Congress: You should do both of these things, not one or the other. You should do both of these things.

DR. NAYLOR: I didn’t think there was a question until it was raised earlier.

MR. HACKBARTH: And we can add language in the text. I’d just as soon not fiddle with changing the word of the recommendation, but we can make it real clear in a text that we’re saying they go together, both. It’s not either/or.

Others?

DR. KANE: Do we already know which quality data we want? I mean is this -- because I noticed in some of the other things where we want quality data, but we don’t -- like LTCHs, we don’t even know yet. You know, we’re holding panels to try to get at that.

I mean if we’re trying to make a recommendation that affects 2012 is there time to have these quality metrics articulated realistically? Or, should we just say

or to begin to develop the -- submit the cost data but begin to develop the quality data in some responsible way?

MR. HACKBARTH: Your point about timing is a good one. So let's assume for the sake of argument I were asked about this in a hearing. What I would say is that we would like to see the legislation that gives the update also include the language that says they must report the data, and the exact time schedule to begin the reporting of the data would be based on working out what the appropriate data are, et cetera.

DR. KANE: Otherwise, it sounds like if you don't give us the data we're not giving you the update.

MR. HACKBARTH: Yeah.

DR. KANE: I don't think the timing is going to --

MR. HACKBARTH: Again, we can use the text to be clear that we think that the mandate for data ought to be concurrent with the update, but no, we don't have the data set. That's not sort of work what we do. That's CMS's province.

DR. KANE: So maybe the notion is that it's concurrent with Congress passing legislation that requires -

MR. HACKBARTH: Yes.

DR. KANE: -- rather than the institution submitting the data.

MR. HACKBARTH: Right, right.

Other round two comments?

Hearing none, all in favor of the recommendation?

Opposed?

Abstentions?

Okay, thank you very much.

Our last session before lunch is on hospital inpatient and outpatient services.

DR. STENSLAND: Good morning. During this session we will discuss the draft update recommendation for Medicare payments to hospitals. Before I start I want to recognize Zach Gaumer, Craig Lisk, and Julian Pettengill who presented earlier analyses to you that led up to today's draft recommendation.

At our December meeting, some of you suggested that we should be more explicit in presenting how the update recommendation and DCI adjustments were computed. We will present those computations more explicitly today as we walk through the following slides.

We evaluate the adequacy of hospital payments as a

whole, meaning we examine whether the amount of money in the system is sufficient. As we discussed last month, Medicare fee-for-service hospital spending grew by roughly 6 percent from 2008 to 2009. This resulted in roughly $148 billion of inpatient prospective payment system Medicare payments to hospitals. Critical access hospital payments represent another $8 billion of payments. Essentially all 4,800 general hospitals in the country participate in Medicare.

During our initial payment adequacy discussion last month, we noted that outpatient volume has been growing rapidly, while inpatient admissions have been declining slightly, and maybe I'll pause a minute to look at those first two -- the first sub-bullets you see under the "Access Is Strong" bullet. One of the sub-bullets notes that office-based visits, visits to physician offices that are hospital-based grew by 9 percent from 2008 to 2009. And in contrast, visits to physician offices that were free-standing only grew by 1 percent. So what this means is we are seeing a significant shift in the site of care from free-standing physician offices to hospital-owned-based practices. And I think as Bob mentioned earlier, there's a lot of anecdotal evidence of why people are doing this.

Certainly part of what people will say is they're preparing for ACOs, they're preparing for -- there are other strategic reasons why they're doing it. But also a big reason that might make it actually feasible when they say we want to employ the physicians is the economics might work out. And one of the reasons is that visits to office-based establishments for the most common physician office visit are about 60 percent higher if it's hospital-owned versus free-standing. So there's this big gap in payments that can be driving some of this shift in site of care we see from free-standing offices to hospital-based offices.

In terms of the other payment adequacy indicators we have, the quality metrics were mixed. Either they did not change significantly or they improved. Access to capital was adequate. And Medicare margins remain low. While Medicare margins improved in 2009 to roughly negative 5 percent, they're expected to drop to negative 7 percent in 2011.

The projected drop in margins in 2011 is primarily due to a reduction in inpatient payment rates. In 2011, the 2.35 percent update was offset by a 2.9 percent reduction in inpatient payment rates that was required by law to recover

past overpayments stemming from documentation and coding improvements. The general idea is that margins improved in 2009 due to overpayments stemming from documentation and coding improvements, and then in 2011 margins will fall back down as CMS reduces payment rates to recapture past overpayments.

Given the negative margins, some of you were concerned about hospitals' overall financial health, and last month, Mike expressed some interest in an early-warning system for financial troubles. So in this slide, we show you two indicators of overall financial health. The first is the total (all payer) margin which represents overall profitability and indicates a hospital's ability to cover its expenses and build reserves for future capital expenditures. The second is what is called EBITDAR on your slide. This is a hospital's earnings before interest, taxes, depreciation, amortization, and rent. It represents a hospital's earnings before capital expenses. In other words, EBITDAR is used to see if a hospital can cover its basic operating expenses.

The first row in this slide shows that overall hospital profitability rose a bit from 2001 to 2006 but is

now back at a more traditional level, with a median profit margin of 3 percent. In the second row, we see that between 11 and 17 percent of hospitals had negative total margins for two of the prior three years during these three different three-year time periods we're looking at. For these hospitals to stay open, they will need to improve their financial performance or find other sources of funding to pay for their capital expenses, and this could be donations or government support. While hospitals with losses are under a greater risk of closure, some do remain open despite continued losses by either receiving government transfers or donations of fixed assets which are often not included in the hospital's income under accounting rules for government and nonprofit providers.

The third row is the EBITDAR margin. It shows hospitals' revenues were generally 10 or 11 percent above their basic operating expenses. We also find that 5 percent of hospitals have negative EBITDAR over two of the prior three years. What this means is the hospitals cannot even cover their operating expenses. To remain viable, they will have to improve their financial performance.

We look at total margins and EBITDAR because we

find that a majority of hospitals that closed had negative total margins and had negative EBITDAR in two of the prior three years. The point is if we see the share of hospitals with negative EBITDAR shifting upward significantly, that would be an early-warning sign that we would be at risk of seeing additional numbers of closures in future years.

Given that we do not see big shifts in total margins or in cash flows as measured by EBITDAR, we expect the rate of closures to remain at its relatively low level in the upcoming years. As you may recall from your mailing materials, over the past 5 years an average of 25 hospitals have closed per year and an average of 54 hospitals have opened per year.

This slide reviews our findings on financial pressure. The main point of this slide is that hospitals under high pressure tend to have lower costs. Lower costs lead to better Medicare margins.

The remaining question is how do the hospitals under pressure -- those with positive Medicare margins -- do overall compared to those that are not under pressure. I think George raised this in December.

If we look at the first column, these hospitals

are under high pressure due to negative non-Medicare margins. The result is lower costs and positive 4.7 percent Medicare margins. However, the Medicare profits are often not enough to overcome the non-Medicare losses, including uncompensated care costs. Hence, the median hospital under high financial pressure has a total -- that means all payer -- margin of negative 0.7 percent. This means that half these hospitals under high pressure are losing money overall. So the point of this first column is to show that some hospitals are struggling, but Medicare is rarely the driver of their overall losses.

In contrast, look at the last column. We see that hospitals that are not facing financial pressure tend to have higher costs and 10 percent losses on Medicare. However, due to high non-Medicare profit margins, these hospitals tend to be more profitable overall. Private profits more than counter balance Medicare losses for these low-pressure hospitals. The point of the last column is that wealthy hospitals that are under low levels of pressure tend to have negative Medicare margins, but those same hospitals often do well overall.

Now let's turn to relatively efficient providers.

As you recall, the point of this slide is that there is a group of hospitals that perform relatively well on quality metrics and still roughly break even on Medicare, with a median margin of 3 percent.

The question raised last month was, How do these hospitals do overall? Are some of these hospitals losing money and in danger of closing despite being efficient?

As we see from the first column, the top performers had a median Medicare margin of 3 percent and a median total margin of 3 percent. Among these top performers, only four of the 219 consistently had losses from 2006 to 2009.

So the key points on this slide are: Some hospitals can do well on quality and cost metrics. These hospitals tend to do better than average on Medicare. And very few of these relatively efficient hospitals have poor overall financial performance.

Now let's switch gears to talking about the need to adjust payments for improved coding and documentation. I want to take a step back and recall why the new MS-DRGs were implemented. Back in 2005 MedPAC did a study of specialty hospitals, and we found certain hospitals were taking the

easier cases, and other hospitals took the more difficult cases. The system had a built-in incentive to specialize in certain types of care, such as cardiac surgery, and to specialize in treating less severely ill patients. So MedPAC recommended paying more for difficult cases and less for easier cases, and this was supposed to be a budget-neutral redistribution of payments.

When the MS-DRGs were implemented, there was an incentive for improved coding to capture the higher payments associated with documenting complications. Hospitals followed the incentives, coding improved, and payments increased. By law CMS needs to make adjustments to payments to offset the coding changes and make the transition to MS-DRGs budget neutral, as we had recommended.

As we stated in December, the Commission has expressed the following principles behind last year's recommendation on DCI adjustments.

The first principle is that the transition to MS-DRGs should be budget neutral. This means that payment rates will have to be reduced by 3.9 percent to prevent further overpayments from continuing. After that is accomplished, additional adjustments will be needed to

recover past overpayments.

The second principle is that these adjustments should occur gradually to prevent a large financial shock to hospitals.

The next slide shows how the DCI adjustments have been factored into the update discussions you have been having during the past month.

First, given the expectations for input prices and the payment adequacy indicators such as volumes, access to capital, Medicare margins, as well as the costs and margins of the relatively efficient hospitals, the Commission's draft recommendation would have been 2.5 percent. This is the first row in the table.

However, there were additional pieces of information that led to a 1-percent draft update recommendation. First, DCI increased payments by 3.9 percent, and those increases will eventually have to be offset. The draft recommendation is to offset 1.5 percent of those increases in 2015. This is the second row.

Turning to the third row, current law requires a productivity adjustment. Last month the Commission discussed that given the need for a DCI adjustment, the

productivity adjustment is not warranted this year. And as Glenn told you earlier this morning, we look at the update on a year-by-year basis, so we're not saying a productivity adjustment will not be appropriate in future years. We are just saying that no adjustment is factored into the 2012 recommendation.

Now, turning to the third row -- I mean turning to the last row, that shows the update recommendation, which is a firm 1 percent. We have eliminated any uncertainty about the DCI adjustment in addition. The DCI adjustment would be 1.5 percentage points. This means that if Congress chooses to follow the update recommendation and payments were updated by 1 percent in 2012, the Commission's position would be that a 1.5-percent documentation and coding adjustment would have occurred. The net result would be that only 2.4 percent of the 3.9 percent in DCI adjustments would be remaining to be taken in future years.

The 1-percent update holds for both inpatient and outpatient payments. The 1-percent increase on the outpatient side is appropriate for two reasons:

First, we see annual outpatient volume growth of 4 percent. And more interestingly, the volume of office

visits for hospital-owned physician practices increased by 9 percent from 2008 to 2009, as I mentioned earlier, and this is significantly higher than the 1-percent growth we saw in visits to free-standing offices. And this, as I said earlier, could reflect the higher level of outpatient payment -- higher level of payments given to hospitals than free-standing physician offices.

The second point is that a 1-percent update would be consistent with the draft update presented for competing ambulatory care sectors such as physician offices.

So given the data presented today on payment adequacy and given the inpatient and outpatient considerations I just discussed in the prior two slides, the draft recommendation now reads as follows: That Congress should increase payment rates for acute-care hospital inpatient and outpatient prospective payment systems in 2012 by 1 percent. Congress should also require the Secretary of Health and Human Services to make adjustments to inpatient payment rates in future years to fully recover all overpayments due to documentation and coding improvements.

The spending implications of this for 2012 is that it is expected to increase spending because our 1-percent

update is higher than what the Congressional Budget Office assumes would occur under current law. Over five years, it would decrease payments due to our recommendation that all past overpayments would be recovered.

We now open it up for discussion.

MR. HACKBARTH: Thank you, Jeff.

I just want to underline a few things that Jeff said in his presentation. First of all, on the diagnosis and coding adjustment issue, I want to emphasize again that there's no implication here that hospitals have done anything wrong in changing their coding practices. Indeed, that's appropriate, required for us to accomplish the basic goal of moving to severity-adjusted DRGs, which is to better allocate the dollars. So nobody should infer from this conversation that we're saying that somehow hospitals are gaming the system or doing anything inappropriate.

Having said that, by definition, changes in case-mix systems should be budget neutral, and that's a principle that MedPAC has emphasized not just in the case of hospitals but for all other provider groups as well.

On the issue of whether or not there is a productivity adjustment here, as I said at the outset, the

format that we are now using for our update recommendations has a couple really important features. One is that we're not going to be characterizing any of our recommendations as a formula going forward. We're going to be using numbers, so it's not going to be market basket minus productivity or full market basket for anybody. We'll actually recommend specific numeric increases.

The second thing that I would emphasize is that our starting point for hospitals and all other provider groups is zero, and there needs to be an affirmative case for either a price increase or price decrease. So the whole notion of a productivity adjustment is not an explicit part of the discussion any longer. We will look at all of the payment adequacy factors and make a judgment year by year about the appropriate increase in payment rates.

The last point I would underline has to do with the outpatient department rates, and as Jeff indicated, we've got a really tricky issue developing with regard to outpatient rates. We started to touch on it in the ASC discussion. There are certain services that are now provided in multiple different locations -- physician offices, ASCs, hospital outpatient departments -- and we pay

different rates based on the type of provider. And the fact that we're paying different rates based on the type of provider for the same service can cause problems. It can cause shifts in the locations of services to take advantage of differences in the payment rates. And there is -- what is the term? Qualitative research?

DR. BERENSON: Qualitative research.

MR. HACKBARTH: Qualitative research that indicates that, in fact, that is becoming an issue, and that hospitals are buying practices and maybe affiliated ASCs in order to take advantage of differences in the rate structure. To the extent that that happens or that process accelerates, it could result in increases in Medicare outlays for the exact same services. So over time we need to look at how to better pay for the same service offered in different types of locations.

Having said that, it's a tricky issue, because we do know for a fact that there are currently differences in the patients that receive the exact same service but in different locations. You know, a type of surgery done on Medicare patients in an ambulatory surgical center, the surgical procedure may be the same, the codes and everything

the same, but the patient could be different than the patient that gets the exact same service in a hospital outpatient department. And folks have heard me say this before. I know that when I ran a large group practice, we systematically directed the patients to different locations based on their co-morbidities, the perceived riskiness of the patient, and the more difficult patients for the exact same procedure we sent to the Brigham outpatient department for the surgery, and the less complex patients we did in an ASC. So there was a conscious sorting of the patients based on perceived risk. And as a result of that, we paid the Brigham a higher rate for doing the same procedure.

So we had sort of an ad hoc payment adjustment that we did through negotiation to take into account the differences in selection of patients. So, yes, we need to try to synchronize these rates more effectively, but it's not going to be a simple task to really do it on an apples-to-apples basis, a really fair basis. So that's a piece of work that we have before us in the future to tackle.

In the meantime, however, we need to be cognizant of the risk in having these rates for hospital outpatient departments and ASCs get further and further apart, because

to the extent that they get further and further apart for treating the exact same patient, the incentives for people to make strategic decisions about buying up practices and ASCs get stronger and stronger and stronger. So we've got a real challenge here in how to deal with this complex problem.

Okay. So now it's time to turn to our Round 1 clarifying questions, and I think this time we are Karen's side. So clarifying questions?

DR. STUART: Yes, I want to pick up on a point that you just raised, Glenn, about the change in the reimbursement for a given service. If a physician office -- if a physician practice was purchased by a hospital, as I understand it, the payment for services provided by the same physicians would include -- in the former case would be the RBRVS for both professional and the practice-related expenses; in the latter case, when they're owned by the hospital, the professional portion would stay the same. The practice portion would then be the hospital outpatient portion.

My question is: Is it possible to track physicians whose practices have been purchased so that we

would have some empirical idea about the increase in the overall cost to the Medicare program?

Then also -- and this hasn't been raised yet, but I think it's important -- there's also an increase to beneficiaries through the Part B co-insurance rate.

DR. STENSLAND: I think we can try to do something in that order, and you're right, it would be higher co-insurance.

DR. CHERNEW: I think, Bruce, you can't do that automatically. In other words, if you want to stay in your same place and just be bought by a hospital, there are rules that you have to be to be able to use the hospital's billing. So it's not [off microphone].

DR. MARK MILLER: Okay. First of all, just to qualify Jeff's comment, we can do some looking around. What I think is going to be very hard to do is to know this practice was purchased by this hospital. Right? I think it will be by inference in terms of the data, billing patterns rather than I can document that. And this is in some ways related to Mike's point. I don't have information yet that I want to go through in a concrete way, but we started making inquiries like how does this work, what are the

rules, that type of things.

There are some rules. The first impression is pretty porous and not clear how much oversight is occurring. I don't want to say this really strongly, but we're starting to dig into this, and like a lot of issues like this, it suddenly turns out to be there are things on the books, but exactly how this is happening is a little bit unclear. So those are the two areas.

Another question is, What are we going to do about all this? The first two areas we're going to look at is the patterns in the data to see if they at least conform to the hypotheses; and, two, how are the rules executed and what do you have to do to jump this fence from one side to the other.

DR. STUART: Do we know if physicians maintain their same IDs if they transition from their own clinic to a hospital-owned clinic?

DR. HAYES: The NPI number that uniquely identifies the physician would appear -- would remain the same for the professional component.

MR. HACKBARTH: Okay. Continuing Round 1 clarifying questions.

DR. KANE: Yeah, I have two clarifying questions. I think one is that the 2.5 percent where we would be in the absence of DCI, and if zero is our base and we've handed out a half and a one to the docs and the ASCs because we don't know anything about their profitability, but we are kind of worried about it -- not too worried, but, you know, we don't want to give them zero. But then we do know these guys are in general, even the profitable ones, even the efficient ones, and if you look at the distribution, some big share of them actually are losing money, so we're giving them to -- I'm just wondering how do we get to 2.5 percent, and it looks an awful lot to me like the market basket.

So I guess I just want to, you know, what are we using to get to 2.5 percent. Is it related to the relative profitability or is it related to something out there? That's just a first question, and I know you want to -- you are going to be able to give me a really cogent explanation.

And the second one is more back to the issue about the outpatient incentives. Does anybody know whether those facility fees get paid to the doctor or get kept by the hospital? And so who's the incentive really for? I mean, if it's the physician, I can understand why they would

definitely want to move their practices, but how do they divvy that up?

DR. STENSLAND: I'll do the easy second one, and Glenn can do the first one. Yes, it goes to the hospital. But, of course, then the hospital's going pay the doctor, and you see this greater and greater share of hospitals have employment relationships with doctors, and they're going to negotiate a salary, and so it's kind of all fungible. You know, the hospital gets the money, but then how much of it does it give the doctor in terms of the salary?

DR. KANE: Well, I guess the one question might be then is the salary in excess of what the professional fee would have generated and how far in excess is it. I mean, you know, this requires a qualitative case study approach probably, but it might be worth getting that sense as well just to get an understanding of how strong is this. I mean, you've got in your text that these outpatient facilities fees are 50 percent, sometimes 50 percent greater than what you would have gotten in a practice expense. That's a big chunk of money, and I remember, you know, in my anecdotal experience, seeing physician practices get put into hospital cost centers all of a sudden. I think I mentioned this

years ago to somebody here, saying, Gee, that seems kind of odd, why are they all doing that? And now I'm beginning to see why with that payment differential. But what is really -- who is benefitting from it? How strong is the incentive? Because if it's really very -- you know, maybe they shouldn't be getting that 50-percent add-on, and maybe what we should be doing instead is, you know, severity-adjusted APGs.

MR. HACKBARTH: I would assume that who gets it is a matter of negotiation. When a practice chooses to sell to the hospital, you know, they would negotiate the financial terms and how much is paid for this, what the salary commitments are. And it would be very difficult to disentangle exactly, you know, what's happened to those dollars. And it will vary based on the negotiations.

I think you're probably chasing something that will be very difficult to run down.

DR. BERENSON: This is anecdotal. I've seen some marketing materials to physicians from law firms as to why they want to consider being acquired which make the point that they can get them a higher purchase price by the reality of these higher payments. So you can't just put it

into their ongoing revenue. It is part of the deal.

The second thing that we really did find this year and would be in anything we write up is that, as opposed to the late '90s when hospitals purchased practices and basically paid a salary, hospitals are using productivity metrics based on RVUs. Now, it seems that most of them are using work RVUs as their productivity metrics and not total RVUs. But it's conceivable that in these productivity adjustments -- I mean productivity-based payments that there is a factor for the higher reimbursement, but that is on a one-on-one -- I mean, that I can't give you anything systematic.

MR. HACKBARTH: Okay. Let's turn to the first question, and let me begin with the statement that with this update recommendation, as with every other update recommendation that we ever do, there's not a right answer that you can calculate. There's probably a range of reasonable potential conclusions, I suppose, to a single point estimate. Congress, however, likes us to give specific numbers, and so hopefully we're hitting within that range.

Here's my logic as to how I arrived at this. I

said let's assume for a second that we didn't have a DCI issue and we were doing a hospital update and focusing, as is our statutory charge, on efficient providers.

Would you put up the efficient provider slide?

So we've got 219 hospitals in the efficient group, which is about 10 percent, roughly, of the total pool of hospitals, and for that group of providers, the average -- or these are medians, right? So the median Medicare margin is 3 percent.

I think, Jeff, you said during your presentation that there actually were only a small number of the 219 that were losing money. Was that --

DR. STENSLAND: If you look consistently over the past four or five years, only four of the 219 have consistently lost money overall.

MR. HACKBARTH: Yeah, so what we have is evidence that there's a group of efficient providers that is able to make a reasonable margin on Medicare business. If this were the only providers that existed, what would we do? Well, as you noted, Nancy, the 2.5 percent is related to the market basket. So if this was the only group out there making a modest positive margin, I would be thinking about something

that goes up with their input prices.

The next step in my thinking was, well, let's look at some other provider groups that might be in a similar situation, and two that came to mind were the dialysis centers that also have a modest positive margin and hospice. But there's a critical difference. We have a 2- or 3-percent positive margin projected for, say, dialysis centers, but that's for all dialysis centers and not just for the efficient providers. And so we're going, when we get to the dialysis discussion, talk about a smaller update for them because we're talking about the full group of dialysis providers, not just this 10 percent really good part of the distribution.

So I'm thinking that we ought to give a higher update, when we're only talking about 10 percent of the population, than we would give for the same average margin when it's the whole pool. And so I think the update I would give for the efficient providers is -- or for hospitals is going to be somewhat higher than I would give for dialysis, and 2.5 percent, around the market basket, seemed within the range of reasonable for me.

Then the second step in my own thinking about this

was that, given the overall distribution of hospital profitability, I was worried about having no update or a rate reduction. And so I said, well, I want to have at least a 1-percent increase in the base rates given the overall financial performance of the hospital sector. And then that leads to the calculation -- if you could put up the other slide, you know, if we would have given the 2.5 percent absent DCI, and we're going to give 1 percent as the minimum we think is appropriate, the differential of the 1.5 percent is the DCI credit.

Now, is that the right answer? Of course, you know, there are other ways that you could think it through and other numbers that you could come to. You could say that maybe not 2.5 percent for the starting point. You could say 2 percent or some other number. And I couldn't say that you're wrong. But that's the logic that I used to get there.

The December discussion coupled with the individual conversations I had with Commissioners after the December meeting sort of led me to think about the problem in those terms, that we needed to sort of step one say what would we have done in the absence of DCI; second step, what

do we think the floor needs to be given the overall performance of the hospital sector; and then from that, derive what the DCI credit is.

DR. KANE: Is it -- I mean, then we start talking about outpatient and inpatient and having different concerns about them, but you want to put the same update on them. I guess that would be the last part of the question.

MR. HACKBARTH: Yeah, and then the hospital outpatient department thinking is very different, because there's not a DCI issue there. And there my thinking is more influenced by this multi-site service issue where we have the same services provided in different sites at very different rates. Right now the hospital outpatient departments tend to be at the high end of that payment distribution, and I think we have to be cognizant, while we work on this problem, of allowing that spread to get bigger and bigger over time. So we're already at the high end, and I don't want to see a 2.5-percent increase there that would make that spread even wider for fear that it would add fuel to the fire of, oh, let's go out and buy practices and convert them to higher payment rates.

Again, you know, there's not a right answer there,

but that's the thinking. I think we need to sort of try to contain the spread in rates while we think through how to handle this multi-site issue.

DR. KANE: Could we consider 1 percent for the hospital inpatient and a half a percent, as we did with ASCs, for the outpatient? Or do we always have to give the one number for the combined?

MR. HACKBARTH: We don't have to do anything. My thinking on -- despite what I said about the multi-site service provider issue, I came in with a lower number for ASCs because of the cost and quality thing. Tom and George and others have really emphasized we need to send a signal there that we've got to get this cost and quality information. And so I wanted to have a slight difference to drive home that point.

Having said that, you know, it does work contrary to this goal of trying to synchronize the rates. So we've got two considerations that are pushing in opposite directions, and this is how I tried to reconcile them. Is it the right answer? No, there is not a right answer to this question. This is simply how I thought through it.

DR. KANE: [off microphone].

MR. HACKBARTH: Okay. Other clarifying questions?

MR. GEORGE MILLER: If you go to Slide 3, please, I have two questions as well. In Slide 3, is the 9-percent increase in the hospital-based office visit total outpatient? Is that a total number? Is that a subset of all outpatient visits, that 9 percent, please?

DR. STENSLAND: So the total all outpatient grew by 4 percent, and then there's a subset of outpatient which is just clinic visits to the hospital-owned physician practices, and that grew by 9 percent.

MR. GEORGE MILLER: So that not a total of all the patient business; that's just a subset.

DR. STENSLAND: The 9 is a subset; the 4 is the total.

MR. GEORGE MILLER: All right. So what percentage of that 9 percent would be of the total outpatient department visits? Can you calculate that or is that --

DR. STENSLAND: Of the growth in outpatient volume, about a quarter of it, about 25 percent was just due to the hospital-based office visits growing by 9 percent.

MR. GEORGE MILLER: Okay. So today -- and I understand Glenn's point -- it could be a big number in the

future, but today this is not a big number then? That 9 percent is not -- that 9 percent is a very small number, a small percentage?

PARTICIPANT: [off microphone] 1 percent.

MR. GEORGE MILLER: Yes, 1 percent, right, exactly. Thank you.

PARTICIPANT: [off microphone] 1 percent of the quarter --

PARTICIPANT: [off microphone] It's a quarter --

MR. GEORGE MILLER: It's a quarter -- right, right, one percentage point. Got it. Okay. But the concern is, as Glenn so eloquently laid out, that because of the pay differential this could be a huge growth area. And I'm just thinking out of the box and off the top of my head, which could be dangerous, but if that's one of your concerns and to keep that from happening, could there be a different payment segment for any new business they acquire? So that if the current hospital rate was set years ago for outpatient, recognizing a whole bunch of different factors, but any -- if a hospital today went out and acquired a physician practice and you're concerned about them doing it for shifting payment, why couldn't we set a different

payment mechanism for that new business and not affect the other business? That may be too complicated?

MR. HACKBARTH: Well, with the same caveat that you offered, that this is off the top of my head -- I obviously haven't thought this through.

MR. GEORGE MILLER: It could be dangerous, too.

[Laughter.]

MR. HACKBARTH: Yes. In fact, in my case I'm sure it's dangerous. I thought I heard a few minutes ago somebody say that actually we don't identify, can't identify when a hospital has purchased an ASC. We can try to infer that, but that's not data that's routinely collected now.

MR. WINTER: [off microphone] It's not accurate.

MR. HACKBARTH: Yeah. So just to do the categorization that is in your model, this is a hospital that acquired this ASC. We don't track things that way right now.

The second thing is that I'm not sure that a two-tier payment system would make sense in the long run. So, you know, we're out now in 2015 or 2020, and we're still going to pay different rates for the same service provided within the same institution based on some acquisition that

happened in the past.

MR. GEORGE MILLER: I understand, but you're concerned about payment at different places now and trying to have them be equitable.

MR. HACKBARTH: Well, I am, and I think we need to try to make sure that we're paying, you know, equal amounts after adjustment for patient differences and the like for the same service, regardless of location. I think that's a sustainable system. Having run out into the future --

MR. GEORGE MILLER: Off the top of my head.

MR. HACKBARTH: -- a difference based on we'll pay X if it was an acquired practice and Y if it was organically grown, I just don't think is a sustainable system in the long run.

MR. GEORGE MILLER: Off the top of my head, but part of my question really dealt with what the other issue was, the concern, because the MA codes are going up, increase, the assumption, is that we then need to be concerned about the increased volume of business, which, you know, you articulated.

My second question has to do with the financial pressure slide, Slide 6, please. Under the high pressure

and the low pressure, can you break down or do you know where they're located and what percentage of Medicare business they do have for each one of those?

DR. STENSLAND: I think the percentage of Medicare business is in your mailing materials, and it's going to be roughly equal.

MR. GEORGE MILLER: Equal, okay.

DR. STENSLAND: In terms of the high pressure and low pressure, there's a wide distribution of where these places are located. In general, the high pressure will tend to be in a little bit poorer areas. If you're in a wealthy area, you're less likely to be under high pressure. But there's a wide distribution of areas.

MR. GEORGE MILLER: But wouldn't that have an impact on this analysis, especially with the location -- and part of the reason was given earlier for some of the differentials of disparities because of dual eligibility or -- because of their location --

MR. HACKBARTH: That's actually the hypothesis here.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: That these are institutions that

tend to have higher Medicaid shares. They've got less generous private payment.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: Therefore, they have to manage their budgets very tightly, and we find that, in fact, they are able to do that consistent with doing pretty well on the quality indicators. And it's that combination, low cost and pretty good performance on quality, that gets them into the efficient provider category. The institutions have a high percentage of private-pay patients, and private-pay patients in particular that come with generous payment amounts. They are not going to be the high-pressure category, and the evidence shows that because they have more money flowing in, they spend more and have higher costs, and that tends to drive down their Medicare profitability. Their overall cost structure goes up. When you compare that to the Medicare payment rate, profitability goes down.

So, yes, the high-pressure category, these are institutions that are compelled by their financial circumstances to manage tightly, and they can do it at a significantly lower cost while preserving quality. That's what makes them efficient.

MR. GEORGE MILLER: Okay. Thank you.

MR. HACKBARTH: Clarifying question?

DR. DEAN: Just a quick question on Slide 2. You said outpatient spending grew by 11, almost 12 percent, but volume went up by 4 percent. Is that just a reflection of the magnitude of the difference in the payments? Or is there something else going on there? I mean, I didn't think it was a three-fold difference, which this would imply.

DR. STENSLAND: Well, there was 4-percent volume growth. There was a pretty healthy update of 3-point-something percent. Then there can be a shift in the types of services provided, and that adds up.

DR. CHERNEW: Service mix increase.

DR. STENSLAND: Service mix increase also. So you have three components: volume, service mix, and price.

MR. HACKBARTH: Okay? Good. Others?

MR. BUTLER: The good news is I'm not going to ask about DCI.

[Laughter.]

MR. HACKBARTH: That is good news, actually.

MR. BUTLER: I'm not going down that rabbit trail.

DR. MARK MILLER: What's the bad news?

[Laughter.]

MR. BUTLER: Okay, I think there's opportunities to create the qualitative research and art of this to more science more quickly than we think, not for this recommendation, but let's go back one more time to Slide 11, just to clarify on this that, you know -- let's not leave the impression that there's incentive for greater volume growth. It's just a shift from the doctor's office into an employment arrangement that actually decreases the physician's component and payment but adds a facility, which in the aggregate pays more and is definitely an incentive and something that needs to be looked at.

But I think one technical question related to this, Jeff, in the materials you sent out, you actually cited an 11-percent increase in the practices, in these visits, and that's 2009; and here you say it's 9 percent.

DR. STENSLAND: There's two sources of data on where you can get this information from. You can look at what is the hospital billing, and the hospital, this is coming off the hospital bills, the outpatient claims, and that's going up by 9 percent. The other source that you can look at that we looked at last time, we decided this is the

one we'll go with. The other one we looked at last time was let's look at what physicians are billing. How often are physicians billing for the complete package of their practice expense and their work as if it's in their office? And how much do they bill it as just for the work component and say they're doing it in a hospital-based practice? And that grew at 11 percent. And these things can be a little different depending on if you maybe have residents delivering the care and they can actually bill themselves, but they still may have the facility fee.

So they're both basically about 10 percent, so the general story is the same, but which data source you use, it will be slightly different.

MR. BUTLER: Okay. So what we need is the slide comparable to what we look at in the physician services in the Part B that builds up the sources of the increase in the outpatient, and you've referenced, for example, I think, that 25 percent of the increase in that year was due to that phenomenon, shifting to -- but we have imaging, we have observation stays, we have a number of things that are building up to the 11-percent increase. So understanding that will help us know how to, you know, take the blunt 1

percent and do it a little bit different in another cycle.

One last technical comment. It's not really a question, but it's around one kind of thing. You threw out there EBITDAR, you know, and we don't have it anywhere in the chapter, and usually it's EBITDA not EBITDAR, so I'm not sure what the -- it's a new -- cash flow is a good one, but I would -- it's kind of an awkward place to insert it because it's not in the chapter at all. That's just a comment because it's not well understood by probably some of the Commissioners, so I wouldn't overuse that as part of anything you would explain on the Hill, for example, at this point in time.

MR. HACKBARTH: Jeff, do you want to just say a little bit more why you chose to add that this time?

DR. STENSLAND: All right. So this came out of last month's discussion in December, and part of it was Mike's desire for the early-warning system. And we wanted to look back at a couple of different metrics. One is the margin, which is a good predictor of closure, and it's also a good predictor of whether you can have enough money to continue to fund capital improvements and to pay off your debt.

I think the EBITDAR is also an important metric in that it basically takes away that debt service and those rental payments, and it really asks more -- will the entity be able to keep on operating even in a bankruptcy situation. And I think the example I would pull out would be from the mid-1990s. What we saw was a lot of nursing homes had taken on a lot of debt or they had taken on big rent obligations. And what happened is a lot of them went bankrupt because they had negative total margins, and they couldn't pay their debt, they go into bankruptcy. But they still had the positive EBITDAR, meaning they could still operate the facility and generate some revenue for those bond holders which now hold the facility.

So what happened is those facilities didn't close and the Medicare patients still had access, they still got their care in those nursing homes, because the cash flow was big enough to keep the operation going, even if it wasn't quite big enough to also pay off the bonds.

So I think there's two different questions: Do you have enough money to pay off all your debt and keep on going? Or do you have money just to keep on going even if you're defaulting on your debt? So that's why I used those

two different metrics.

MR. BUTLER: I just found the timing of the insertion of the concept, even if you're responding to Mike, was a little -- and rent usually -- that is a cash outlay. It's part of running -- you know, it's usually not part of it. So I would just -- but I understand your response.

MR. HACKBARTH: [Off microphone] Okay. Round 2 comments.

MR. ARMSTRONG: Just two brief comments.

First, Glenn, I thought you did a great job of summarizing this issue of how do we deal with paying differently for essentially the same or similar services but just provided in different locations. The only point I wanted to add to that is that I look forward to our consideration of what do you do with that. I think there are similar issues in some of the post-acute areas as well, and so as we organize that, my hope is it would be a fairly broad kind of consideration.

Second, hospital reimbursement is going to change so much in the next few years. There are so many different variables, whether it's what we just heard about the value-based payments, the IT reimbursement, the impact of ACOs and

what that means, or changes in reimbursement relative to readmissions, and even more than I'm even aware of. I would just -- I support this recommendation, but in the years ahead, somehow I'd like to understand better how all of those come together and impact, you know, the very measures we use to judge whether these rate changes are appropriate rate changes. It just seems -- I'm worried that there are so many moving parts. I think they're all headed towards certain common policy goals, but exactly what the net impact of all of them is at this point, for me anyway, is very difficult to know.

DR. BAICKER: I like the framing of the update preserving the policy tool of a budget-neutral rejiggering of the risk payment, so I think making it explicit what share of that we think has been reclaimed and what share is remaining to be reclaimed is very helpful, and that might argue for being even more explicit in the discussion of the outpatient versus the inpatient because they're coming to the same bottom line. We don't want that to muddy the waters because there are these very different pieces going on, and I think they can -- in the discussion they were a little bit conflated.

DR. KANE: I agree with Kate, and I guess the other piece, I think I'm very concerned about what we're seeing on the outpatient side and how much that might cost us. And I just wonder if we shouldn't also try to get in, at least the text if not the recommendation, that somebody, CMS or somebody should start looking into sort of severity-adjusted APGs, you know, hospital outpatient system the way we had to do on the inpatient side, and with the goal ultimately of saying, you know, the same price wherever it goes. Because, you know, your story about higher -- it just assumes, you know, that patients that are going to the hospital are all 50 percent more resource intensive, which they aren't. I mean, they're something more, but they're not -- and I think that what we really should be doing is just adjusting for the severity of people going for outpatient -- for any kind of office visit if we think the APGs are way off. I mean, if they're way different than the physician payment because you think they're sicker, we should be able to show that and create -- and, otherwise, there's just this terrible incentive to put a whole lot of people in the hospital-based visit and just cost the program a lot of money at a time when it's not -- you know, we're

really trying to reduce unnecessary expenditures.

So unless we can fix that severity adjustment, then I think I'm sort of in George's camp of we should try to find ways to stop the excess payment that's happening with this sort of strategic change of employing physicians.

MR. GEORGE MILLER: Yeah, in principle, I support the draft recommendation and agree with what has been said. I'm still struggling a little bit on the outpatient side, particularly because in the chapter the margin's so much worse on the outpatient side. And I didn't ask this in the Round 1 clarifying questions, but we see increase in hospitals, in bad debt, an increase in Medicaid because of the general economy, and that has an impact on the hospital's overall structure, and with that increase in negative margins, you know, I guess I'm a little bit concerned about just a 1-percent increase in the outpatient margin in light of all the other discussion. So just making that comment.

And as you look at efficient hospitals, you did it overall. I didn't see what the outpatient margins were and if they've improved them overall in that analysis if you just isolated the outpatient volume. But it was just

negative -- it's very negative, 10 percent, if I remember correctly.

MR. KUHN: First of all, I just want to thank Glenn and Mark and Jeff and Julian for spending a great deal of time with myself and Peter and George as we kind of walked through the DCI issue on a number of different calls and conversations over the last several months.

Having said that, I'll support the recommendation that we have. However, I think over the next year I would like us to continue to revisit this issue of the DCI. I think we're pretty good on refinements in terms of the calculation, but I'd like to explore other options for calculation as we go forward, because this issue is going to be with us for a while, and I just want to make sure that we're as accurate as possible in terms of our calculation, because it's not only here, but as we all know, on all the payment systems, and ultimately when we get to ACOs and they get into the normalization issue, we're going to be having to make these kind of calculations over and over again. So the efforts I think we can continue to do here to try to refine how we calculate coding would be very helpful.

DR. BERENSON: Yeah, I just want to say I'm with

Scott that we need to deal with this place of service issue, and I see the conflicts that you've laid out. On the one hand, we are supposed to capture the underlying costs to the entity and pay them appropriately, and at the same time we don't want distorted behavior which we create. And I think there's some conflict in those two things. And so I think a similar thing is going on in post-acute, and that's what I wanted to -- but I think there may be some general principles. Some of this may have to do with how the costs are being allocated into which services, and maybe there's a way to look at that, et cetera. But I just think it's an important issue that's increasing in importance.

DR. NAYLOR: So I support the recommendation. I think the difference between the outpatient adjustment of 1 percent versus ambulatory care centers of half is at this point in time, given that we don't have data on cost and quality from the latter, justified on the differences in case-mix and the RAND study that shows these are very different people overall in multiple case-mix variables, age and insurance status and race, that are being served right now in the hospital outpatient, et cetera.

Then one other comment is the real need to

continue to look at quality, and as we're looking at high performance or -- because that is part of our charge to look at the most efficient, and concerns raised in this great chapter about the growing body of evidence that's showing a disconnect between hospital process measures and key measures of mortality, readmission, et cetera. So as we're thinking about who it is we're looking at as our benchmark, our need to really, I don't know, help advance an agenda for better quality measures and better ones that show relationships in efficiency.

MS. HANSEN: I support the recommendation, but I'd like to harken back to actually three comments here. I think Scott and Bob's comment about this whole piece, and then at some point perhaps what Nancy brought up was, again, the severity-adjusted ambulatory side so that it's more centric to the beneficiary in terms of that. But two points that came up in last month's meeting that I just wanted to raise that I think is relevant here. As these forms are molting, there are impacts that happen to both physician providers as well as the beneficiaries. The observational stays that we discussed last time was one example, that as we tried to negotiate to make this system whole, there are

consequences to some of the players, and two I just wanted to identify I understand. Physicians may not get paid quite the same way for the services that they're providing when it's in a different setting just because the payment goes to another entity, and then again, reiterating that oftentimes patients who end up going back into the hospital not as a readmission, because that becomes an anathema and they go in for observational days, if they end up still getting the similar services but get post-acute care, they may have a much higher co-pay issue.

So I think these things are -- you know, as these things are kind of flowing, there are sequelae that I think we need to highlight and make sure are taken into consideration.

MR. BUTLER: I, too, would like to congratulate and thank the staff for all the hard work on a number of fronts on this year's cycle.

I just have one additional point, and that is, the reason I like the 1 percent is not necessarily the amount. The predictability is very, very important. I think that, you know, we sit here with the DCI, and we in hospitals don't sit there, okay, how much did we get out of coding

last month or this month. We just track the case-mix index and try to project forward, you know, in our budget what are we going to get. So October 1 comes, and if you know it's 1 percent on whatever you're running, it's a much more stable way of moving forward than getting whipsawed around by, you know, what are they going to swipe out of here or there. And that's not an unimportant point, and the same has been said of the physicians, on SGR and everything else. Some predictability is important.

DR. CHERNEW: I just want to say that in response to some of these issues of payment, it's going to be an incredibly difficult and very time-consuming process to try and get all the new case-mix right based on where you're going and how you're doing and developing a new case-mix. And I imagine I might be different than some around the table, but I think spending a lot of time on developing new and more refined ways of doing fee-for-service spending in, you know, a code-specific way as we go forward for organizational forms to change and technologies to change and systems that we still can't seem to get them exactly right on the relative payment stuff for ones we've been working for a long time strikes me as a lot less important

than emphasizing much more strongly this is extremely why we need to try and do the broader payment reform stuff that we unfortunately don't get to talk about this month.

MR. HACKBARTH: Okay. On that note we are ready to vote on the recommendation. All in favor of the recommendation, please raise your hand?

Opposed?

Abstentions?

Okay. Thank you, Jeff.

So we are now at the public comment period. We'll have a brief public comment period in advance of lunch. Let me quickly review the ground rules. Please begin by identifying yourself and your organization, and limit your comments, please, to no more than two minutes. When this red light comes back on, that will signify the end of your two minutes. And for those of you towards the end of the line, if, in fact, a person in front of the line has made similar comments to yours, please feel free to say, "I agree with Speaker 1," and not feel the need to repeat everything.

With that?

DR. CALVERT: Commissioners, my name is Preston Calvert. Can you hear me okay? I'm the president of the

North American Neuro-Ophthalmology Society. It's a professional society of about 500 members representing the practicing neuro-ophthalmologists in the United States. Neuro-ophthalmologists, as some of you know, are cognitive subspecialists who initially trained in either ophthalmology or neurology and then have at least an additional year of fellowship training in neuro-ophthalmology. All of our members are board-certified in their primary specialty.

I'm here to ask that you reconsider your now year-old policy to stop Medicare payment for consultation services by specialists. The daily work of our members involves consultations performed at the request of other physicians for their patients with unexplained inability to see properly, double vision, facial and head pain, and many other complaints. Our consultation service includes eliciting a complete medical history and a detailed physical exam done by the doctor him- or herself, often of both complete neurologic and visual systems, gathering of complete records of all prior care for that patient, for this patients' problem, and then a careful review of all of the imaging studies that have been done in relation to the problem.

There's extensive time required to inform the patient of our findings and to plan further evaluation and treatment. We regularly diagnose and treat brain tumors, multiple sclerosis, myasthenia gravis, stroke, and many other serious conditions.

It's a daily occurrence for every neuro-ophthalmologist to properly diagnose and treat patients who have been previously undiagnosed or misdiagnosed. It has immediate and life-changing effects for the well-being of our patients and other doctors' patients.

The Commission's main focus is on large-scale measures of patient access to the most frequently required services by primary care and high-frequency specialty practitioners. Your assessment by surveys and the accessibility of specialty services to Medicare beneficiaries necessarily is dominated by responses regarding high-volume specialties. However, some of the perceived quality of American health care and our system is related to ready access to expert diagnostic and therapeutic expertise for less frequent but potentially devastating medical conditions. Access to these specialists that provide these cognitive services is not likely to be well

capture by the surveys that you use.

Neuro-ophthalmology is poorly remunerated in the best of times. Its practitioners work out of the love of this discipline and a devotion to patient care, research, and teaching rather than any pecuniary motive. Since the lost of the consult codes under the Medicare billing system, in the past year our members have reported a significant drop in their practice revenues related to the particular prevalence of Medicare beneficiaries in our practices. Some of our members have begun refusing Medicare patient consultations and assignment, and some are considering opting out altogether. We've begun to see early retirements of members in the prime of their careers for financial reasons. And we're troubled by this because we see a problem in attracting young people to join our specialty. This specialty attracts a very specific kind of person who's attracted to those features, and we are losing even the basic recognition of the work of this subspecialty in the Medicare payment system.

One of the major points that I'd point out to you is that there's been a breakage of the fundamental mechanism of medical communication in the failure to require a report

from a consultant back to the referring physician. You broke that when you changed the fee system. And that had to have been an unintended consequence. I'm sure you did not mean to do that.

So we ask that you either restore the Medicare consultation codes for reimbursement directly or consider some kind of MPI-based multiplier for initial inpatient and outpatient visits from physicians who are recognized as cognitive specialists to reimburse their efforts for their patients. Failure to take those steps will degrade our ability to care for those patients and the ability of their primary physicians to obtain those consultations. And it clearly is the case that patient outcomes will worsen, and we actually have substantial studies to prove that patient costs, costs to the system will increase as well.

Thank you.

DR. MARK MILLER: The only thing I would clarify quickly for the public is the change in the consultation rules was not a policy change made by MedPAC. It was made by CMS, and at least at the time, CMS' justification for it was that the reporting requirements for the consultations had been lowered. Just so that if you're sitting here

wondering what decision he's referring to on your part, it was actually a CMS decision.

MR. HACKBARTH: Okay. And before the next commenter begins, I know that a couple minutes doesn't seem like much, but I would emphasize that this is not your only or even your best opportunity to provide input to the work of the Commission. Rest assured that on the consultation issue we've received a lot of letters that have made the points that you've made. There have been face-to-face meetings with staff and representatives of various organizations. So I must limit you to just a couple minutes. We've got a very full agenda, and we're already behind.

DR. LAING: Hi. With that introduction, thank you. I'm Tim Laing. I'm with the American College of Rheumatology. I'm a rheumatologist. I'll save you at least one of those two minutes because I really wanted to support the foregoing comments and state that in our society we are very concerned that the workforce issues and access issues that result from the inability to recognize specialty expertise anywhere in the fee schedule -- I also serve as our RUC adviser -- just seems like a decision that really

should be changed somehow, some way, and we'd really appreciate your consideration.

Thank you.

DR. McQUILLEN: Hi, I'm Dan McQuillen. I'm the Chair of the Infectious Disease Society, Clinical Affairs Committee, and I'm a practicing infectious disease physician at the Lahey Clinic in Burlington, Mass.

I'd echo similar comments to what have been made before. I've heard personally as part of my role of practitioners in ID who have stopped seeing Medicare patients, decreasing access; one at least, perhaps two that have closed their ID practices because of that decision by Medicare.

We see a lot of opportunities going forward in terms of when payment reform gets going, particularly in accountable care organizations. We have about 9,000 board-certified infectious disease physicians in our membership, and I think, though we're small, we have a disproportionate effect on many of the things that are important going forward in terms of accountable care organizations, quality of care, preventing infections.

One of the problems with the decision made by

Medicare is that it makes our financial viability a little bit suspect going forward. We've already seen some decrease in applicants in terms of our fellowship positions. What we would like to discuss with you -- and we've sent, as you mentioned, letters about this -- is ways in which we can incentivize this sort of program. ID doctors are the ones that run, design, implement infection prevention programs, antimicrobial stewardship. We see opportunities there in the non-patient care activity payment arena to subsidize some of our activities and make our profession a little bit more economically viable while actually helping the system overall.

Thanks very much.

DS. CHANG: Good afternoon. My name is Sharon B. Chang. I'm speaking to you on behalf of the Ambulatory Surgery Centers Association. We just wanted to say again how much we're encouraged by the direction that the Commission is taking in looking across the multiple settings where surgery can be provided and also very encouraged about the direction you're taking in terms of quality.

Just to reiterate, we have as an industry asked CMS each time over the last several years that this has come

up to institute a quality reporting system for the ASC setting. Over 1,000 ASCs already voluntarily report on six NQF-endorsed quality measures. We'd love to see that go voluntarily nationwide so that consumers can be part of the movement that you're also talking about of getting a savings from Medicare every time a patient chooses on the basis of quality and appropriateness to have that procedure in an ASC versus an HOPD. When that's appropriate for that client, the Medicare program saves money each time.

We'd love to see an opportunity actually to bring those two threads together. As we look forward to 2011, one of the things that we hope to see from CMS is a design for a value-based purchasing system that would run for ASCs, and if that gives us an opportunity to demonstrate quality and efficiency for the Medicare program, we think that's a win for the ASCs and for the beneficiaries.

Thank you very much for the encouraging direction.

DR. DONOFRIO: Thank you. My name is Peter Donofrio. I'm a neurologist from Tennessee, and I'm representing the American Academy of Neurology. I would just like to mention our support for restoration of the consultation codes. Contrary to some of the data we saw

from MedPAC today, neurologists are seeing fewer people with Medicare. About 30 percent of our candidates in a recent survey mentioned that they were spending less time with patients with Medicare and seeing fewer of them.

My second point is that neurologists actually are the primary care physicians or principal care physicians for people with certain chronic neurologic conditions like multiple sclerosis, ALS, and Parkinsonism. So the bonus given to the people in primary care was certainly warranted, but we think there should be bonuses for certain chronic illnesses cared for by people speaking at this microphone today.

Then, finally, neurologists do save money. There is data from the American Academy of Neurology that neurologists save money in the area of stroke and multiple sclerosis because we spend more time with patients but order fewer tests, and we have better outcomes.

Thank you.

MR. HACKBARTH: Okay. We will adjourn for lunch and reconvene in 45 minutes, which is at 1:30.

[Whereupon, at 12:46 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:36 p.m.]

MR. HACKBARTH: Okay, it's time for us to begin again with Nancy's presentation on outpatient dialysis services. And Nancy, would you go ahead, and I'll stick my head out the door and round up the last couple of commissioners?

MS. RAY: Good afternoon. During today's presentation, I'm going to first follow up on some questions from the December meeting. Then I'm going to summarize information about the adequacy of Medicare's payments for outpatient dialysis services. I will present a draft recommendation for you to consider about updating payments for calendar year 2012. This is, of course, your last presentation before the March report.

Just quickly, an overview of the dialysis sector: In 2009, there were about 340,000 fee-for-service beneficiaries who sought care from more than 5,000 ESRD facilities. Medicare's spending for composite rate services -- that is the dialysis treatment -- and separate payments for dialysis drugs totaled about $9.2 billion in 2009. Dialysis drugs accounted for about one-third of this total.

So several commissioners had questions from last

month, and I'm going to try to answer your questions.

George, you had a question about accounting for new medical innovations under the new payment method. As we have seen through the years, one of the many advantages of prospective payment systems is that they allow for a lot of innovation without any action by Medicare. They just flow into the payment bundle.

According to MIPPA, the ESRD bundle under the new payment method includes other items and services in addition to the composite rate services, dialysis drugs and labs that are furnished to individuals for the treatment of end-stage renal disease. This provision suggests that the Secretary has the flexibility of augmenting the bundle over time. That being said, I'm not a lawyer, so we will monitor this.

Karen, you had a question about physician disclosure. Physicians can have ownership interests in dialysis facilities and other financial interests as well. Your mailing materials give some examples of the financial interests that physicians have with one of the large chains. Our 2009 recommendation on disclosure of physician ownership would help CMS and other payers determine the extent to which physician financial interest influences quality of

care, volume and spending.

Herb, you had a question on collecting data on dialysis patient satisfaction. AHRQ has developed a CAHPS in-center hemodialysis survey instrument; this is for adults. The survey instrument is up on the web site. That being said, there is no regular reporting of this information either by CMS or the CAHPS folks.

In a related issue, CMS's new conditions for coverage requires facilities to include patient satisfaction as one of their components of their QAPI program, their Quality Assessment and Performance Improvement program. The final rule that was issued in 2008 encourages facilities to use this standardized tool, but the agency did not require the use of the instrument.

Nancy, you had a question on pre-ESRD care, and we've included a text box in the draft chapter on the benefits of pre-ESRD care which includes educating chronic disease patients before they start dialysis about their renal treatment options and better managing their chronic kidney disease comorbidities including hypertension and cardiovascular conditions.

A few years back the Commission looked at the

provision of pre-ESRD care to fee-for-service beneficiaries older than 65, and this was before they started dialysis. Like other researchers, we found that early referral to a nephrology team reduced some morbidities associated with ESRD including increased use of home dialysis and increased use of AV fistulas. A related policy began in 2010 with Medicare paying for the educating pre-ESRD beneficiaries about kidney disease.

Tom, you wanted to see the distribution of driving miles for new fee-for-service dialysis beneficiaries. This is included in the paper, and I'm going to present you the findings in about one minute when I summarize the payment adequacy findings.

Okay, Bob, Jennie and Karen, we have included renal-related quality measures in the draft chapter. The chapter notes that a substantial portion of hospitalizations are due to renal-related comorbidities including vascular access and infections. We've included the one-year survival for dialysis patients, which is higher for African Americans and other races than whites. We've included vascular access complication rates and find that AV fistula patients have a lower rate of declotting procedures than graft patients, and

catheter patients have the highest rate of sepsis compared to fistulas and grafts.

So I'd like to shift gears and review the payment adequacy information. You've seen all of this information last month. Overall, our indicators are positive. Supply and capacity is increasing. In the past year, facilities and stations increased by about 4 percent.

Looking at the volume of services furnished by facilities, we see the growth in the number of dialysis treatments continues to match beneficiary growth. Use on a per-treatment basis of erythropoietin, the dominant dialysis drug, increased between 2008 and 2009. In addition, the aggregate use of other dialysis drugs, holding price constant, also increased between 2008 and 2009.

In terms of beneficiary access to care, it's generally good. There was a net increase of about 250 facilities with few facility closures. About 60 facilities closed. They are smaller and less profitable than the existing facilities.

We did see a greater representation of African Americans and beneficiaries dually eligible for Medicare and Medicaid treated by closed facilities. That being said,

this affected less than 1 percent of these beneficiaries.

We did see that the two large dialysis organizations that account for 60 percent of all facilities continue to treat these beneficiary groups.

In addition, we looked at the distances beneficiaries traveled to obtain care as another measure of access -- that is ease of obtaining care -- as well as the potential effect of facility closures. This analysis finds that the distances that new patients traveled to obtain care remained relatively unchanged in 2004, 2006 and 2008, including for African Americans and duals.

And here are the median distances to the dialysis facility as well as the distribution in terms of the 25th and 75th percentiles for some key groups including elderly, African Americans, duals and beneficiaries residing in rural areas. I'd like to highlight for African Americans and duals, the two groups impacted by closures, the travel distances, median travel distances remain constant or went down slightly between 2004 and 2008.

Quality is mixed. Some measures are high or improving. Others still need improvement.

In terms of access to capital, it appears to be

good for both the large dialysis organizations and other chains. Both groups have been able to obtain capital for acquisitions. Investor analysts and private equity firms generally look favorably upon this sector.

Here's the 2000 Medicare margin for composite rate services and dialysis drugs. You saw this last month. It is 3.1 percent. This is relatively unchanged from 2008. The stable margin is linked to increased use of erythropoietin between 2008 and 2009 and the 1 percent update in the composite rate in 2009.

As in previous years, the Medicare margin varies across provider types. It was largest for the two largest chains than for everybody else.

We are concerned about the direction of the margin for rural facilities. That being said, this year in 2001, under the new dialysis payment method, a low volume adjuster is being implemented, and this will increase payment for qualifying facilities by 18.9 percent. Rural facilities will disproportionally benefit from this adjustment. CMS projected that 45 percent of the facilities who get a low volume adjustment are rural. By contrast, about one-quarter of facilities are located in rural areas.

The projected margin for 2011 is 1.3 percent. This includes the MIPPA 2 percent reduction, the 3.1 percent transitional budget neutrality adjustment and the 2.5 percent 2011 payment update. This projection also includes a conservative behavioral offset to account for efficiencies expected under the new payment method.

So this draft recommendation attempts to balance being cost conscious and assuring that providers can handle cost growth, and it reads: The Congress should update the outpatient dialysis payment rate by 1 percent for calendar year 2012.

In terms of spending, this recommendation would decrease spending relative to current law. Under current law, current law calls for an update of the market basket less productivity, which would currently result in an update of about 1.6 percent. This draft recommendation will decrease beneficiary copayments relative to current law.

Thank you.

MR. HACKBARTH: Thank you, Nancy.

Let's see. So we're starting over on this side, round one clarifying questions, Mitra and then Jennie.

MS. BEHROOZI: Thank you, Nancy. In the paper,

you talk about costs increasing, the components of the increases in costs, and you show that the general and administrative costs have risen during the period 2004 to 2009 by 6 percent per year and account for nearly 30 percent of the total costs, whereas the direct patient care costs -- for example, one dear to my heart, the labor costs -- have gone up only 2 percent per year, and in fact some of the other direct medical costs have decreased by 0.2 percent per year.

So I thought that greater consolidation, leading to efficiency, really ought to have an impact on the general and administrative side as well, right, one infrastructure to deal with more patients. So this is really kind of counterintuitive to me. Do you know why?

Do you see any evidence of particular things? Is there a huge explosion in malpractice costs or something for these facilities?

And do you know how this compares to other sectors where we have data on administrative costs, both the growth and the total share of that 30 percent?

MS. RAY: The answer to your second question, how this relates to other sectors, I'm kind of looking for

somebody else to help me out on that one.

DR. MARK MILLER: [Inaudible.]

MS. RAY: Yeah, in relation to the first, with respect to the first one, you know, over the past, gosh, I'm going to say about five years or so, we have seen higher growth in G&A than the other components. And I'm trying to think back to what folks have told me about it, but -- so in a way, I'd like to get back to you on that, but I do think it is linked to malpractice and some of the other cost components feeding into the G&A. At least that's what they have claimed.

DR. MARK MILLER: All right, what we've come up with on advice of counsel is it's slower at least in the hospital setting, in the 4 percent range; 6 percent, you guys were talking about on dialysis. Meanwhile, we'll keep looking in the background on the post-acute care side.

And did you get her first answer? Okay.

MS. RAY: [Inaudible.]

MS. HANSEN: Thanks, Nancy, for answering everybody's questions here. There were earlier questions that we've had about home dialysis, and I notice that with some of the counseling there's probably some greater

increase. A question is do these same companies that provide the sited dialysis actually operate the home dialysis programs as well?

MS. RAY: Yes, yes.

MS. HANSEN: Yes, okay. And what is the -- is there a significant or just really tiny growth in the home dialysis programs?

MS. RAY: You know, over the past I guess 10 to 15 years we've actually seen a decline in the number of home dialysis patients. The dominant home dialysis modality right now is peritoneal dialysis although there are patients undergoing home hemodialysis as well -- the more frequent during the day and nocturnal home hemo in the evening.

Under the new payment method, there's some thought. Some people are expecting over the long term for the use of home dialysis to increase, again because dialysis drugs will not be included in the payment bundle.

Under the previous payment method, the profitability of dialysis drugs might have been one of the reasons for the decreasing use of home hemo, of home dialysis because in general home dialysis patients use less dialysis drugs than in-center hemo. So, but we'll have to

monitor what happens under the broader bundle.

MR. HACKBARTH: [Off microphone.] Round one clarifying questions?

DR. BERENSON: Yeah, this is a quick one. We had an article that we reviewed that suggests there might be the potential of more than three dialyses a week, producing higher quality, going to five or six day a week. Under the current rules, would there be a full dialysis payment if you went to more than the current number?

MS. RAY: Right, that's a really good question. So right now, even under the broader bundles, CMS pays for up to three treatments per week. A physician can get a fourth treatment paid for by going to the local contractor medical director.

That being said, the NIH trial on more frequent -- you're referring to the NIH trial, more frequent hemodialysis, and found improved cardiovascular outcomes in physical health than the conventional three times a week. And I think this is an issue that we plan to think about a little bit more in the next cycle.

DR. BERENSON: Right now, Medicare payment policy would have a chilling effect on that ability to do that, to

have more than three?

MS. RAY: Well, again, the medical directors at the local contractors do pay for the fourth session if it is -- if the physician can justify it as being medically necessary for fluid overload, et cetera. So that is being done right now.

The question is given the NIH trial results --

DR. BERENSON: Which changes the standard of care, not just an exception for a particular patient.

MS. RAY: Exactly, and I think that's something we here have to think about a little bit more.

DR. BERENSON: Okay, thanks.

MR. KUHN: Thanks, Nancy. A couple quick questions, one on the low volume adjuster. There was some chatter at one time that that could create an incentive for gaming in the system, but CMS I think in the final rule did put some provisions in there to prevent gaming; that is for facilities to kind of reduce their size, so they could get that nearly 19 percent added on payment. Do we feel like the anti-gaming provisions are strong enough?

MS. RAY: So what CMS did is it said for new facilities. So for a facility to qualify they have to

provide under 4,000 treatments for the 3 years prior to the payment year, and for new facilities the way they count the 4,000 is they look at are there any other facilities of common ownership within 25 miles of that facility.

MR. KUHN: Within a geographic area.

MS. RAY: So that is, I believe, their mechanism to try to ensure that low volume is truly a low volume facility.

That's -- I was going to say as we move forward that is one item that we are going to focus on.

MR. KUHN: Thanks.

MR. HACKBARTH: On the same topic, I assume that the low volume adjustment is calculated in an attempt to calculate what the increase is in your variable costs due to low volume?

MS. RAY: Yes.

MR. HACKBARTH: It actually would be your average costs --

MS. RAY: Yes.

MR. HACKBARTH: -- to low volume.

MS. RAY: Right.

MR. HACKBARTH: And so if that calculation is

right, you know, your costs should go up if you disaggregate and go into smaller units

MR. KUHN: Right.

MR. HACKBARTH: And so there shouldn't be a huge gaming opportunity is where I'm headed.

MS. RAY: Well, I think there was -- I think some might have been concerned that: Well, this 18.9 percent adjustment. Well, gee, let's just start reducing the number of treatments we furnish, or let's start opening little, smaller size facilities.

MR. HACKBARTH: Yeah.

MS. RAY: I guess that's the better example.

MR. HACKBARTH: Yeah.

MS. RAY: And so what CMS is saying is: Well, but if there's -- if you're Dialysis Chain A, ACME, if you have any facilities in a 25-mile radius, we're going to count that in, in terms of the total treatment count.

MR. KUHN: So that would be for common ownership among facilities.

MS. RAY: Yeah.

MR. KUHN: Just one other quick thing, Nancy, one other thing to ask is CMS originally, when they created the

prospective payment system, had a four-year transition. I think their early impact analysis was around 45, 50 percent of the facilities would opt out and decide to go in immediately, but instead a much higher proportion. What was that proportion that went in?

MS. RAY: So CMS projected that 45 percent would opt into the new payment method. According to the industry, it looks -- the industry is saying, based on their survey, about 90 percent of all facilities have opted into the new payment method.

MR. KUHN: And why did they? What's our kind of initial analysis why we think that CMS missed the mark in terms of its impact, so by an order of magnitude of 100 percent?

MS. RAY: Oh, well, I don't want to speak for CMS, but they did it facility-by-facility I think, and so they didn't recognize that if you're a chain organization you're going to probably make a decision based for all of your or none of your facilities.

I think there was also -- I've read that some organizations, I guess to minimize complexity, just wanted to not have to deal with both the new payment method and the

old payment method and just opted for the new payment method.

MR. KUHN: One just observation I make, Glenn, is this: So many times, people around this table and people who stand up to the microphone at this table do tend to criticize CMS a lot, but I think one inference we could draw from this particular PPS system, that the reason we have such a high compliance rate, CMS got it. And I think this is one where we kind of need to pat CMS on the back --

MS. RAY: Yeah.

MR. KUHN: -- and give them the credit they do, that they got this one right the first time out with the industry response at such a high level it was. So good for the agency.

MR. HACKBARTH: And you might expect that CMS might tend to underestimate the savings potential when you move to a new payment system, and those who run the facilities have a better sense of oh, if I get paid in this new way, you know, I can cut out this cost, that cost, and do well under the new payment system. And so the benefit of having the inside knowledge of operations may account for that differential.

George.

MR. GEORGE MILLER: Thank you, and I want to thank you and the staff again for the excellent information, particularly demographic information in the chapter. I appreciate it very much.

I've got two quick round one questions. I've got a broader one for round two.

First of all, Jennie's question, mine is similar to that. In home dialysis, what percentage of the total -- and it may have been in the chapter, I just don't remember -- of the total dialysis is home dialysis? And it seems that we can save the system money if we encourage that more often.

I guess part of my question is why is it included in the bundled payment for all facilities versus separately to try to encourage and use more home dialysis?

MS. RAY: Right now, I think roughly about 10 percent --

MR. GEORGE MILLER: Ten percent.

MS. RAY: -- of dialysis patients are dialyzing at home. So the -- for adults, the bundle payment rate pays the same for home dialysis and for in-center hemodialysis.

Now when you're comparing the in-center hemo versus the home peritoneal dialysis, in general on average, the cost per peritoneal dialysis patient is lower than for in-center hemo.

MR. GEORGE MILLER: Right.

MS. RAY: So, you know, there is the thought that this broader bundle could be incentivizing peritoneal dialysis. There is still the outstanding question, however, for more frequent home hemodialysis which is something that we're planning on looking at.

MR. GEORGE MILLER: Okay, I guess that's part of my question. I'm not sure if I'm explaining it correctly. If the goal is to increase home dialysis in either way, is the bundle -- my question is: Is the bundle payment that is included, will that generate more home dialysis or will not generate more home dialysis, the way I read it in the chapter?

MS. RAY: I think all things being equal. I mean if providers' costs are lower for having --

MR. GEORGE MILLER: Home.

MS. RAY: -- home peritoneal dialysis than in-center hemodialysis --

MR. GEORGE MILLER: Right.

MS. RAY: -- you may over the long term start to see a shift towards peritoneal dialysis.

MR. GEORGE MILLER: Okay.

MS. RAY: That being said, you know, facilities still have stations and chairs that they have to fill. So I think, you know, one has to be balanced with the other.

And you know, not everybody is a candidate for either.

MR. GEORGE MILLER: Candidate, right.

MS. RAY: I mean -- you know. There's a lot of other factors involved in whether, you know, a patient dialyzes at home or in-center.

MR. GEORGE MILLER: Okay. And then the follow-up question, I don't remember reading it in the chapter, but it seems to me from what I'm reading that the sooner that a patient is referred to a nephrologist that that would save more money in the system. We would not see more hospitalizations. So I don't know if there's a lever or mechanism to deal with that issue, but in discussing with my nephrologist in my hometown and others it seems their concern is that they don't get referrals early enough, and

if there's a way to have an impact that we could get referrals we'd save the system some money and get folks appropriate care sooner.

MS. RAY: Right, so just a couple of items to follow up on that. So Medicare, beginning in 2010, has begun to pay for this pre-ESRD education which hopefully, assuming the individual has been identified as having chronic kidney disease, they can -- I think they can receive up to five or six sessions on counseling, including how better to manage their comorbidities and giving them all the different options including transplantation and home dialysis, and kind of also providing them with better knowledge about what may be down the road when they begin dialysis.

In terms of cost savings, we found in our analysis that there was some reduction in patient spending. That was, I think, primarily focused on the first year of dialysis. After that, and again I have to go back and double-check those numbers. But the cost savings, I'm not sure. I'm not sure how much was past the first year of dialysis.

MR. HACKBARTH: Okay, round one questions,

clarifying questions?

I see none. Let's proceed to round two comments.

Mitra.

MS. BEHROOZI: It's really a follow-up to my round one comment, that you know I think it's worth paying some attention to, not in this cycle but for the next cycle perhaps. You know. Just in comparison to hospitals, the growth in general and administration is 50 percent higher in this realm, and 30 percent of the costs being administrative just doesn't sound like, you know, it should go unchecked without us examining it.

MS. RAY: I do want to say something though. Under the broader bundle, so that distribution may change because again that's composite rate.

But that being said -- what? That's cost, that's -- but that's composite rate only. Of course under the broader bundle, now you're going to have drugs and labs in there as well. So the proportions are going to change between the labor and the G&A and all those.

But that being said, your point is valid.

DR. KANE: A question, where do the health insurance costs fall? And I'm wondering if that's not -- is

that in administrative costs or is that in labor costs? Do we know where they fall because that could be why they're growing so fast?

MR. HACKBARTH: Nancy, what do you mean by health insurance costs?

DR. KANE: The health insurance costs for the employees.

MR. HACKBARTH: Oh, for the employees.

DR. KANE: Yeah, that's often one of the fastest growing and largest pieces of it. It depends on where it's classified.

MR. HACKBARTH: Yeah.

MS. BEHROOZI: But that's why I ask what it is in other sectors. I mean if they were the same.

MR. HACKBARTH: Yeah. It would suffice to say I think it does bear some further investigation. All other things being equal, you would think the rapid consolidation in the industry would tend to suppress the rate of growth in G&A. And for it to be that high and higher than some others, it's worth looking into further.

MS. HANSEN: This goes back to one of the measures of quality and the fact that not going onto transplantation

lists, and so two questions more about kind of the trending issues.

One is this transplantation matter. Are there sufficient donors, you know, for a growing list of people who would be on a transplantation list? That's one thing.

And the other one is more of an epidemiology question. Given the rate of adult obesity and older people with issues, is there kind of a factor of what this program is going to look like over time in terms of its growth rate and expense, the whole dialysis program?

MS. RAY: In terms of sufficient donors, I mean I think there is the idea that I think folks would like to increase the number of kidney donors. You know, people carrying the cards.

MS. HANSEN: Well, part of my question is this is quality metric, and so we're getting people on lists. Is that considered one of the measures that you'd look for, good counseling or something, as part of quality?

MS. RAY: Okay, okay, I'm sorry. Okay. If your question is about having dialysis patients worked up and included on the kidney transplantation list --

MS. HANSEN: Right.

MS. RAY: -- yes, that is a metric, and there you do see differences across different provider types and by demographics as we pointed out in the text. So that is something that you would want to see an increase in the number of patients being put up, being included on the transplantation wait list.

The pre-ESRD counseling could help increase that by educating patients about their treatment options. You do hear often patients saying: Well, gee, nobody told me about home dialysis. Nobody told me about transplantation.

I mean there is that, and there is the -- there are researchers who have shown that people who have been referred to a nephrology team earlier, before starting dialysis, have higher rates of being on a kidney transplant list than those who don't see a nephrologist until they require dialysis.

In terms of the dialysis growth trends in total, you know we did see a decrease just in this current, I think between 2007 and 2008, in the rate of ESRD related to diabetes, and that is a first, and that could be because of the use of therapies to delay end-stage renal disease. That being said, you know, I do think that -- I think the growth

rate in this area is still predicted to be --

MS. HANSEN: An increase.

MS. RAY: Increase, yeah.

MS. HANSEN: And relative to the other question about the quality metric, I think being counseled for the option sounds great. I guess I'm looking at it practically, as just where the back end. Getting on a list is one thing, but getting an actual transplant is another.

MS. RAY: Absolutely, and there are a limited number of donors, yeah.

DR. DEAN: A couple of things. First of all, just a comment, I think I mentioned this last time, that I'm still bothered a bit by the quality incentive program which seems to me to be based on a very narrow set of indicators. We have a whole list of things that are relatively easy to measure. In fact, they're already here. And things like hospitalization, infection, nutritional status -- those data are already being collected. They're really important for long-term outcomes, and they're things that need to be monitored. So I'm just struck that they're not included in the program.

Secondly, I appreciate your laying out the travel

challenges and the distances traveled. I guess I just make the point that 25 percent of dialysis patients still travel more than 22 miles, which is a challenge, and it's especially a challenge if we're really looking at more frequent dialysis.

And I think there's really a tradeoff there because if you look at that paper the compliance rate dropped compared to standard dialysis. As the frequency of dialysis went up, the compliance rate went down. It's a real burden to have somebody to have to go in five or six times a week to, you know, wherever they may have to go.

So there clearly are medical advantages to it, and you get a better, more effective dialysis process. On the other hand, there are some human factors that really work in the other direction, and so it's just a complicated business, I think.

But I think we just -- we want to be cautious that we don't jump too rapidly to the idea that since the renal function may improve. There are other things in the way.

MS. RAY: I just want to say something about the quality incentive program that's beginning, that will begin in 2012. For the first year of the program, MIPPA laid out

the measures. So that's what the agency is using in terms of the anemia and dialysis adequacy. In the proposed and final rule, CMS did express interest in adding additional measures to that, so.

MR. HACKBARTH: Round two comments?

MR. KUHN: First of all, I support the recommendation that we have before us.

And then also, Nancy, I appreciated in your comments, I think on page 9 of the overheads, when you were talking about the margins, the rural margin was down, and that is a cause for us to pay close attention to. I know that low volume adjuster will be an important factor in that.

But also as I recall in MIPPA there was also the opportunity for the Secretary to implement a facility-level adjuster which the Secretary chose not to do, but I think that's something that I'd like us to continue to monitor as well as an option in the future if we don't see those rural facilities performing like we think they ought to perform.

MS. RAY: Just to be clear, MIPPA gave the Secretary the authority in addition to the low volume adjuster to also implement a rural adjustment in the

proposed and final rule, and the Secretary opted not to, again citing the applicability of the low volume adjuster for rural facilities.

MR. GEORGE MILLER: I just want to follow up on my colleague Jennie's comments concerning kidney transplants. First of all, I do want to recognize and commend and I'm very pleased that both the Asian Americans and Native Americans that account for 6 percent of end-stage renal disease, that they count for 10 percent of the transplants, and that's absolutely fantastic and remarkable. And I wonder what we learn from that. Why? What is it that was done to improve that percentage?

But what I am struck with and concerned about the inequitable situation it seems between African Americans that make up 32 percent but only get 24 percent and what can be done to improve that issue. For me, it's problematic. It has been that way for some time now. And I guess I'm struggling to put something specific that should be done, but I do want to raise the issue.

I talked with the nephrologist who said that it should be required. The problem is the workup, and it's about a year workup, and there should be some mechanism to

require. Even though it may be difficult, some of the socioeconomic factors may be strong and prevalent, but it should be a requirement -- his requirement, a requirement that a person requiring the position spend about a year in a workup to make sure that number is improved.

And I don't know if we have any recommendations. That's just a concern. It may be more of an observation about that issue, but I do appreciate the information here. I think we should continue to monitor it and maybe as a goal to see if that's increased. But it is an inequity and so a problematic inequity for me.

MR. HACKBARTH: Has there been research, Nancy, on trying to explain the reason for the differential?

MS. RAY: I think there is a lot of different factors that affect the transplantation rate. Some of it is that again patients may not be informed about their renal treatment options, and that's something that should be actionable. And again, the pre-ESRD counseling is hopefully one way to rectify it.

There's the biologic matching process which maybe somebody else around this table could better explain than me because I know I'll screw it up, and that has been --

DR. MARK MILLER: Just on that point, and I'll screw it up too, because we spent a fair amount of time and had some clinicians come in and talk about it, and it was quite striking to me that there is quite a lot that goes on and a lot of places that do. And Karen could probably.

DR. BORMAN: The things that are most determinate of transplant survival, if you will, the organ transplant survival, relate to that matching, and that matching is genetically determined, and so that within shared gene pools certain patterns of genetics are more common. And so, it's not something that anybody does or controls. It relates to the extent that there are shared genes within different ethnic groups. So that part is largely uncontrollable.

Perhaps the intervention that relates to that would be more donors from that shared gene pool, and the donation rates vary widely across ethnicities. In fact, there's one group that will accept organs but not donate them, categorically, which is a little bit of a troubling ethical circumstance when you're in transplant medicine.

So I think that the only way I know, George, to come at that piece of it is education campaigns, and I'm aware of at least one campaign in north Texas that was

extraordinarily effective in boosting the donor rate from minority groups. So that would be one way to attack that.

MR. HACKBARTH: Other round two comments?

Karen.

DR. BORMAN: Just a couple of things. I think this is a very fine effort, and Nancy, thank you for trying to answer my questions and comments. I appreciate your and staff's efforts.

Just a couple of things I would emphasize. I think there is no question that, for example, infection rates will be least in AV fistula than they are in graft than they are in catheters. That's never going to change. That is inherent in the nature of those things, and so we need to be a little bit careful in creating implication that we can get everybody to the best case scenario.

While we would love to do it, there are many patients that by the time they come to vascular access who no longer have a suitable vein to create. And vascular surgeons have been very creative, transposing and moving around veins within the upper arm in order to attempt to do that, but there is a point at which you kind of reach diminishing returns. So I'd like to be just a little bit

careful about creating any implication out there that we can get to nirvana fairly quickly.

The second, and that also would relate a little bit to the considerations about peritoneal dialysis and home hemodialysis, those -- peritoneal dialysis has some very specific contraindications related to people who have had multiple prior abdominal operations, for example. There's not enough access to the surface lining inside the abdominal cavity to allow effective peritoneal dialysis -- so again, a factor that's outside of everybody's control. And I think we want to be just a little bit careful about saying that: Wow, these things are cheaper. They're as efficient. We should get everybody there.

We should make all reasonable efforts, but the reality is we aren't going to get everybody there. And we need to make sure that our quality measurements and so forth allow for those exceptions and appropriate identifications of where we can succeed and where we can't.

Similarly, home hemodialysis takes a pretty motivated family, a pretty motivated patient, and we need to be a little bit careful about those things. But you know absolutely those things, when we can achieve them, achieve a

better goal.

And I thank you for taking forward the work of including transplantation and things that surround it as a measure because I think at the end of the day if we had enough donors and we could catch people at the right time we'd go a long way toward ameliorating this particular disease.

MR. HACKBARTH: Thanks, Karen. That's very helpful information.

So I think we are ready to vote on that recommendation. All in favor of the recommendation, please raise your hand.

Opposed?

Abstentions?

Okay, well done, Nancy. Thank you.

Next is home health.

MR. CHRISTMAN: Good afternoon. As Glenn said, next, we're going to do home health. And just as a brief refresher, here's some basic stats on home health. In 2009, Medicare spent about $19 billion on home health services. There are over 11,000 agencies that participate in the benefit in 2010 and they served over six million episodes

for three million beneficiaries in 2009.

We will review the framework and several recommendations to improve program integrity, payment adequacy, and payment accuracy, as well as beneficiary incentives. The recap of the framework, which we covered in depth at the December meeting, will be brief in order to preserve time for Commissioner discussion. I can provide additional clarifications during the Q and A, if necessary.

Here is an overview of our indicators. Beneficiaries have good access to care in most areas. Ninety-nine percent of beneficiaries live in an area served by one home health agency. Sixty percent live in an area served by ten or more. We have noted there are some areas that lack access, but in some instances, it appears that a lack of access is related to factors other than Medicare payment.

For example, we spoke with representatives of one State that indicated low Medicaid payments and declining local subsidies were discouraging agencies from providing services in rural areas. Nationwide, Medicare payments do not appear to be a problem in rural areas, as rural agencies have margins of 16.6 percent. The margin for rural remote

agencies is over 19 percent. And in addition, there is a three percent payment add-on in effect for rural episodes in 2010 through 2015.

The number of agencies continues to increase, with over 3,800 new agencies entering Medicare since 2000, and we have reached over 11,000 agencies in 2010, as I mentioned earlier. The number of episodes and rate of use continue to rise, and the annual rate of increase in episode volume appears to be accelerating. And as we reviewed last month, quality shows improvement on most measures. Access to capital is adequate for both private and publicly-held agencies. And the margins for 2011 are projected to equal 14.5 percent. These margins are consistent with our findings for previous years. For example, margins have averaged 17.5 percent since 2001.

Overall, these indicators are very similar to what we have reported in prior years, and next, we're going to look at recommendations.

Many Commissioners at the last meeting felt that our recommendation on fraud needed to be emphasized, so we will begin here. For many years, we have noted aberrant patterns of utilization in home health. This slide lists

the 25 counties with the highest frequency of home health use in 2008. If you compare the share of users and the episodes per user for each county for the national average, which is listed below and to the left in yellow, you will see that these counties are well above average in home health utilization. Note that the share of beneficiaries using is two to four times the national average, while the average number of episodes is also significantly greater than the national average, and five of these counties have more home health episodes than fee-for-service beneficiaries.

Differences of this magnitude raise concern that fraud may be an issue in some areas, particularly because some of these areas, such as Miami, have already seen significant program integrity activities. We cannot make definitive judgments about the role of fraud in high-use areas from this data, but differences of this magnitude suggest a need for closer inspection, and if fraud is revealed to be a factor, swift action.

Medicare has new authorities to fight fraud in the PPACA and home health may be an appropriate place to test them. Specifically in areas where the Secretary concludes

there is widespread risk of fraud, she can implement local moratoria on the enrollment of new providers and suspend payment for services in areas that appear to have widespread fraud.

This brings me to a recommendation. It reads, "The Secretary with the Office of the Inspector General should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud."

This will decrease spending for home health if implemented -- now, these savings are already assumed in the budget baseline by CBO -- and there would be some administrative costs. In terms of beneficiary and provider implications, appropriately targeted reviews should not significantly affect beneficiary access to care or provider willingness to serve them.

Next, we turn to payment adequacy. Before I take you through the 2012 recommendation, let me remind Commissioners of changes in the PPACA. The PPACA implemented a phased rebasing which begins in 2014 and is

phased in over four years. The reductions would be limited to no more than 3.5 percent a year and this reduction would be offset each year by the payment update. Given the positive indicators for the industry, the delay seems unnecessary. In addition, including the market basket update as an offset makes these reductions similar and in some cases smaller than those the industry has weathered in the past, so would likely result in agencies maintaining high margins.

Here is the payment adequacy recommendation for 2012. It calls for an acceleration of the rebasing already in law to 2013 and the elimination of the market basket update for 2012. The recommendation reads, "The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket update for 2012."

The spending implications are that this would reduce spending by $750 million to $2 billion in 2012 and $5 to $10 billion over five years. Some providers may choose to withdraw from the program. Remaining supply should provide adequate access to care.

In addition to concerns about the high margins,

there has also been a concern about the distribution of payments and whether the payment system provides appropriate incentives. First, as discussed in prior meetings, the inclusion of therapy visits as a factor in the PPS allows agencies to follow financial incentives when determining the number of therapy visits provided. An analysis by the Urban Institute found that the current system is highly dependent on the use of therapy as a predictor for its accuracy. With therapy as a predictor, the system could explain 55 percent of costs. Without it, the explanatory value dropped to 7.6 percent. Perhaps most importantly, the current case-mix explained one-tenth of one percent of the variation in non-therapy costs, meaning the system is weakest in explaining the services that are most commonly provided. Most notably, the case-mix properly identified only 15 percent of the highest-cost non-therapy episodes.

All of these factors suggest the case-mix system needs to change. If the current system remains in place, agencies will have an incentive to avoid non-therapy cases, base the amount of therapy provided on payment incentives and not patient characteristics, and avoid high-cost non-therapy cases.

Urban developed a revised system that did not use therapy visits as a factor in setting payments and relied solely on patient characteristics. The revised system they developed explained about 15 percent of costs, or about double the explanatory value of the current system when its therapy thresholds are removed. The improvement was better at the service level. For non-therapy services, the explanatory value of the revised model was 15 percent, compared to eight percent for the current case-mix without its therapy thresholds. For therapy services, the revised model had an explanatory value that was more than double the current system without therapy thresholds. The revised system was also more accurate in identifying high-cost non-therapy cases, identifying 28 percent of them, again, nearly double the current model. This analysis suggests that an alternative case-mix which drops the therapy thresholds would have better accuracy and better incentives than the current system.

This leads to a draft recommendation. It reads, "The Secretary should revise the home health case-mix to rely on patient characteristics to set payment for therapy and non-therapy services and no longer use the number of

therapy visits as a payment factor."

Now, this change would be budget neutral, and in terms of beneficiary and provider implications, it would increase access to care for non-therapy patients and payments will generally be redistributed to providers that focus on non-therapy services from those that are more focused on therapy services. Another way to think of this is that it would level the playing field between providers that deliver more therapy and those that deliver more non-therapy. Currently, the payment system appears to overpay for therapy services and our proposed changes reduces payments for those services and redistributes them to non-therapy services, which appear to be disadvantaged under the current system. Payments would increase for dual eligibles and patients who need the most non-therapy services. At the provider level, we would see increases for nonprofit, rural, and hospital-based providers.

Another issue is ensuring appropriate use of the home health benefit. Today, physicians and home health agencies are accountable for following Medicare's enrollment and coverage standards, but several studies have raised questions about how effectively they serve this role. Many

reports suggest that the locus of control often remains with agencies which have a financial interest in eligibility and plan of care decisions. This conflict is even more troublesome considering the 50 percent increase in home health] volume that has occurred since 2001.

Concerns about over-utilization are further exacerbated by the lack of cost sharing in home health. Studies have generally found that beneficiaries consume more health care services when they have limited or no cost sharing and that these additional services do not always contribute to better health. The rapid rise in home health volume suggests that at least some of this growth may be increasing Medicare's costs without improving beneficiary health. Adding a copay requirement would permit patient choice to serve as an offset to the incentives in the Home Health PPS, which reward additional volume. However, the copay needs to set appropriate incentives. It should not drive beneficiaries to other high-cost settings and minimize the impact for high-need and low-income patients.

With these concerns, there are essentially three questions to answer: What unit the visit or episode should the copay be charged at, when should it be charged, and how

much it should be. These questions present a number of competing policy goals and I will now walk through a design that shows one approach to balancing the various concerns.

The first choice is selecting the unit. A copay could be charged at the per visit or per episode level, but given the incentives that providers have to deliver more episodes, a per episode copay seems appropriate. The per episode copay would encourage beneficiaries to weigh the need for care at the onset of an episode. Typically, Medicare relies on physicians to drive this decision, but some Commissioners have said that physicians do not always have the information they need to make these decisions and that they sometimes face consumer pressure from beneficiaries. An episode-level copay would encourage the beneficiary to explore alternatives more fully with their doctor.

An episode copay would also be more appropriate given the incentives of providers under PPS. Under the PPS, providers receive a fixed payment for each episode so they have an incentive to produce more episodes but generally have no incentive to produce more visits. A per visit copay would provide an incentive for beneficiaries to decline

additional visits and this would increase provider profits because fewer visits would lower provider costs per episode. A per episode copay would also help to keep the beneficiary liability predictable and limited. The amount would be known at the onset of care and would not increase for sicker beneficiaries who need more visits.

Selecting which episodes we wish to charge cost sharing for is a second step. Because of the nature of current cost sharing arrangements, community-admitted episodes, those that do not have a prior acute episode, appear to be more appropriate for cost sharing than post-hospital or PAC episodes. Post-hospital patients have other settings, such as SNFs or IRFs, that generally have limited or no cost sharing. Charging home health cost sharing for these patients could have the effect of shifting patients from home health to other more costly settings.

For patients in the community, the situation is different. They face 20 percent coinsurance for most services, but pay no cost sharing for home health. Because home health is more expensive to Medicare than office visits, this arrangement presents a perverse incentive that encourages beneficiaries to consider the costs of office

visits, but not home health. Also remember the community-admitted episodes account for a disproportionate amount of the growth in home health services. Focusing cost sharing on this category would ensure that only episodes beneficiaries place some minimal value on would be delivered.

A final issue is the amount. The amount of the copay depends on the minimum amount of value you would want a beneficiary to place on an episode and how strongly you want them to consider alternatives. The goal is to charge an amount that is not so high as to be overly burdensome and not so low as to cause beneficiaries to under-value home health services and use them when they provide minimal value or other less-costly alternatives would suffice.

One way of anchoring this discussion is to start with the 20 percent coinsurance a community-dwelling beneficiary would typically incur for outpatient services. However, this would yield the relatively high amount of about $600 in 2008, an amount equal to more than half of the inpatient deductible. A lower amount of $150 would arguably be less burdensome and maintain some incentive for beneficiaries to consider alternatives. Amortized across

the typical non-outlier episode, this amount would come out to about $8 per visit for the $150 copay. This amount is less than what comparable office visits would typically cost the beneficiary. For example, a 45-minute visit with a physician or physical therapist would cost the beneficiary about $20 per visit. Under the $150 copay, a 45-minute visit at home with a therapist or nurse would cost the beneficiary on average about $8, or less than half what they would pay if they went to the office.

Bringing together the various concerns I have just walked through, an illustrative copay could look like this. A fixed per episode amount of $150 would balance concerns of affordability with the desire for an effective beneficiary incentive. Focusing on community-admitted episodes would make the cost sharing incentives for home health consistent with other services provided in the community and avoid perverse incentives that could drive beneficiaries to higher-cost settings. We could exclude low-use episodes, those with four or fewer visits, so the low-use beneficiaries are not disproportionately affected, and dual eligibles would not have to pay because these costs would be picked up by Medicaid. With these parameters, the copay

would affect about one-third of episodes in 2008.

Here is a draft recommendation which would establish a copay as I just described. "The Congress should direct the Secretary to establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use."

The spending implications are that this would reduce spending by $250 to $750 million in 2012 and $1 to $5 billion over five years. Now, in terms of beneficiary and provider implications, some beneficiaries who need relatively few services would have lower cost sharing if they substituted ambulatory care for home health care.

Now, that completes the new recommendations that we plan to vote on today. We also plan to reprint the third recommendation from last year that sets up a framework for patient safeguards. This recommendation addresses concerns that providers may stint on care when the rebasing is implemented. Under this recommendation, Medicare would monitor the payments and quality of care provided during the rebasing. If it appears that highly profitable agencies are reducing services and lowering quality to maintain margins when payments are rebased, this recommendation would permit

Medicare to reclaim excess payments and redistribute them to agencies with better quality and lower margins. And again, this is unchanged from last year.

This final slide sort of provides a brief summary of the four different recommendations and is for your reference. I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Evan.

Let's see. I think it's Karen's turn this time. Any clarifying questions, Karen, Scott, Bruce, Kate, Nancy, George.

MR. GEORGE MILLER: Just quickly, talking about the copay, in the reading, there was some material that said -- in the reading material, there was a statement that said that the HIE study found that some health outcomes were worse for low-income beneficiaries subject to higher cost sharing, and I realize you did an analysis saying that the dual eligibles would be exempted, but what about low-income folks? This study seems to indicate that even for someone who has low income, they may not take the benefit or take the services because they have to pay a copay. Any reaction to that, or are there other studies that show that this would be mitigated in any way? I'm just concerned. You've

got dual eligibles covered, although you said Medicaid. Are we talking about Medicare paying it or Medicaid also on the dual eligibles?

MR. CHRISTMAN: I'm sorry. What I meant to say is that dual eligible Medicare and Medicaid beneficiaries, you know, their costs would be handled through Medicaid.

MR. GEORGE MILLER: Medicaid.

MR. CHRISTMAN: Yes.

MR. GEORGE MILLER: You said Medicaid, okay, which is a different issue.

MR. HACKBARTH: On the first issue, George, which is an important issue, it's true for any copay -

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- whether it's for home health or physician services or the hospital inpatient deductible. It can have a disproportionate impact on low-income people. In Medicare, as you well know, the way we deal with the people who are lowest income is through the dual eligibility and payment through Medicaid. But low income is a spectrum, a gradation --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- and just because you're a

dollar above the cutoff doesn't mean that there's no effect on you.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: So it's inherent in copayment. On the other side of the coin, there are some benefits from copayment which I won't go through. You know those, so --

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: I don't have a simple solution for that.

DR. MARK MILLER: I would just add one other thing to that. In addition to dual eligible, remember we also have this structured so that the home health episode following the hospitalization, where the sense is that it's clear of the medical necessity, is not subject to it. In HIE's stuff, remember, that stuff was very much more focused on kind of hospital physician, and I think a big complex issue with the home health benefit is exactly how much is needed and when is enough enough. And so we have tried to think that through. Close to the hospital, no payment. Second, third episode, that's when it applies.

MR. GEORGE MILLER: But in general, I'll just make a -- I don't know if I should wait until round two -- a

philosophical statement. I'm really concerned about the fraud and abuse, extraordinarily concerned about that. For those who are listening, the industry and the peers have an equal responsibility to this. This is absolutely shameful, this amount of fraud and abuse, especially by the graph that was put up. There are ways to deal with it if the industry won't take care of it itself and we shall do that.

MR. HACKBARTH: Fraud and abuse is an important problem, but it's not the entirety of the utilization problem. And so there are issues about people electing to use a service when there's no cost consequence for them, it's a free service for them, and substitute for family members and other sorts of support. And at the extreme, and this benefit can sort of turn into a long-term care social support service as opposed to the acute benefit that it's supposed to be, and a modest copay is potentially one tool to help deal with that problem. But it is not, as you say, without issues.

MR. CHRISTMAN: One point I would just note is that under the illustrative copay we've come up with, that for most beneficiaries, home health would still be a cheaper place to get the services than getting the services on an

outpatient basis. So for those low-income beneficiaries, this is an opportunity for -- it would still be a low-cost substitute.

MR. HACKBARTH: [Off microphone.] Clarifying questions?

DR. NAYLOR: Thanks, Evan, for a terrific response to all of the questions we raised earlier. I'm wondering if you could comment just generally on -- the Affordable Care Act has multiple provisions to try to promote use of home and community-based services, broadly defined, as substitutes for higher-cost services, such as the emergency department or hospital. Does this notion of accelerating rebasing or eliminating the market basket update earlier have consequences, potential unintended consequences beyond that which might be removing from markets multiple players?

MR. CHRISTMAN: I mean, I think certainly, you know, whenever you're talking about pulling a significant amount of money out of a payment system, it's going to discourage some people from entering and it's going to, you know, some people may exit. I think what I would say is that the changes that are happening as a result of the PPACA or even in our recommendations are relatively modest

compared to the reductions the industry experienced in the 1990s. They cut home health payments in half between 1997 and 1998, and at the nadir of the contraction that that triggered, there were over 6,500 home health agencies in America. I don't remember the exact number. And so it does complicate whether or not people are available to participate in those new models, but I guess it's -- a significant number of agencies will likely remain in the program and certainly enough, I would think, to try out new models. You know, on the flip side, I think some agencies will look at these new models as a, for lack of a better term, potential lifeboat to deal with the reductions that are coming.

MR. HACKBARTH: I just want to add one thing on that, Mary, for the benefit of the audience. I know you know this. Our draft recommendation in December said a zero update for fiscal 2012 and begin rebasing in 2012, and if you put up the relevant recommendation, Evan, and what we've done is modify that to have zero update in 2012 and begin rebasing in 2013. As you point out, that is still one year ahead of what is envisioned in PPACA. The reason for deferring that one year in our recommendation is to increase

the likelihood that we will have the new case-mix adjustment system in place, and that was something that was discussed in our December meeting. I just wanted to flag that for people in the audience.

You were going to ask another question, Mary, or -- are you sure? Clarifying questions, Mitra and Peter and Mike.

MS. BEHROOZI: I'm sorry. I think you just addressed the first one. So by not putting a date for the revision of the case-mix adjustor, that means we're recommending that it be done immediately, as soon as possible, I mean, is that --

MR. HACKBARTH: As quickly as possible, and I don't know, Evan, if you might want to add anything to that, but that would be the intent, that this is an urgent matter that has a significant effect on the distribution of payments and one that we think is beneficial, and so as quickly as possible.

MS. BEHROOZI: And -- oh.

DR. MARK MILLER: I was just going to say, and also that there is enough research around that we think there's enough critical mass that they could pick it up and

do something in a reasonable amount of time.

MS. BEHROOZI: We don't need to specifically say that it has to happen concurrently, like in our other recommendation about the payment to ASCs along with the data?

MR. HACKBARTH: The audience for the two recommendations is -- well, actually, let me just think about this. So CMS is responsible for the case-mix system, and which other recommendation would you make it concurrent with, the rebasing?

MS. BEHROOZI: Or in advance of. No, I was referring back to our ASC recommendation where we explicitly state concurrently --

MR. HACKBARTH: Yes --

MS. BEHROOZI: -- which I thought might not even be strong enough, but at least we state that much. Here, we don't have any data on the rebasing or --

MR. HACKBARTH: Yes. So I'm just thinking aloud here, Mitra. Help me with it. So the timing of the rebasing is a recommendation to the Congress. The acceleration of the case-mix adjustment is an exhortation, if you will, to CMS. So the audiences are different, which

may make the juxtaposition that way a little awkward in a recommendation. Having said that, I think we could be very strong in the language in the text about the urgency of the new case-mix system.

DR. MARK MILLER: And it's not for certain, but if the -- and it is in law that rebasing is to occur, right, it's on some schedule. One other way to think about it, and the industry can speak for itself, is if that train is coming, then the adjustment for the case-mix should become something that they see as more urgent so that there's some leveling up of the payments before the rebasing occurs. And so one would hope there would be some critical mass from a couple of directions if they think that rebasing train is coming.

MS. BEHROOZI: Yes. I guess there's just the concern that rebasing happens and they haven't gotten around to implementing the case-mix adjustor, and as you say in the paper, Evan, that could really damage the low-margin agencies who are doing good work, not just because they're not good at managing. So I think that's the concern, because, of course, there's a lot of focus on the high-margin agencies or maybe the places where there's fraud or

whatever, but that shouldn't drive the whole discussion. We have to look at the bottom side, too.

And I just wanted to ask another question about -- with respect to copays and comparing them or relating them to copayments with respect to other services. Could you just talk, Evan, about what the Medigap coverage -- we had discussed that explicitly in the prior session on home health, but now it's out of the recommendation, out of the presentation, but could you discuss what would happen with respect to Medigap coverage?

MR. CHRISTMAN: I'm going to start to answer and hope Scott will come up here and join me. My understanding is that the process of what is covered under Medigap is governed by the NAIC process, National Association of Insurance Commissioners, and that they sort of have to regulate what is in those plans and that that process takes some time to complete.

DR. HARRISON: Right. So the way copays are covered under Medigap is there are categories of services. Right now, there's not a copay for the category of service home health. So what would have to happen is the model plans would have to change and that usually takes a year or

two.

MR. HACKBARTH: Evan, under the first issue, it occurs to me that maybe one approach might be to be very explicit in the text and say, we have -- this recommends rebasing begin in 2013. We had previously considered 2012. We have deferred that in the expectation that by the time rebasing begins, there would be a new case-mix system in place and we think that's important, something along those lines.

MR. BUTLER: So I have two questions. One is that we have $19 billion in home care spending, and now that we're in the post-acute world discussion where Medicare has a much bigger role, what's the total spending on home care, roughly?

MR. CHRISTMAN: I don't know that off the top of my head. I mean, if you throw in the Medicaid and the private pay, I believe it's north of $40 billion.

DR. MARK MILLER: Evan, do you know in freestanding what proportion of their business is Medicare?

MR. CHRISTMAN: Um -

DR. MARK MILLER: I'm sorry --

MR. CHRISTMAN: It's been a while since I've

looked at it.

DR. MARK MILLER: All right. I'm sorry. I thought that would help you size it, but --

MR. BUTLER: There's some reference to Medicaid episodes at the end, but okay. So actually, I thought it would be much more than 50 percent of the total. So let me ask a different question. Obviously, there's an area where there's variation, as George pointed out, due to fraud and abuse, but there's a lot more going on than that. An interesting question would be to look at the MA plans and see if the variation is reduced within -- not the absolute spending in those plans, but, in fact, is there variation and is the variation in kind of the same places as it is in the fee-for-service world, because it'll tell you how much of that is part of the solve for right-sizing and aligning the post-acute world.

MR. HACKBARTH: I don't know what the data would show, but my hypothesis -- in fact, we talked about this at an earlier meeting, that in a plan like Scott's, home health is a service that is closely monitored and integrated into the clinical care plan in a way that all too often it is not in the wild, I think was Mike's expression, in the fee-for-

service sector. And so I would think that there probably would be a difference in the patterns.

MR. BUTLER: So what would be really stunning is if you went in the heart of some of those counties where there's the biggest variation and showed that the MA world is operating totally different. Then you really could draw some strong conclusions about that as a lever for handling post-acute care.

DR. CHERNEW: I want to essentially ask a variant of Mitra's questions, but for Medicaid and the duals. The way the recommendation is presented now, the one that we're voting on, the copay one, will Medicaid automatically fill in that copay for the duals or do there have to be changes administratively done in the Medicaid programs, so in the short run, if a Medicaid program facing financial pressure decided not to pick up the extra copay portion for the duals, that that would therefore fall on the duals. Is the Medicaid law, we cover all your copays and if the copays change, we just cover that, or is the Medicaid law, we cover these copays and if the copays change, then they have to change the Medicaid law to fill it in?

MR. CHRISTMAN: I think the short answer to your

question is that when the cost sharing changes like this for Medicare is that Medicaid pretty much instantaneously has to pick it up. Now, there's a wrinkle. The wrinkle is that at the States' option, they don't have to pay the copay if the amount of Medicare's payment for the service is higher than the State Medicaid payment for that same service.

MR. HACKBARTH: So there are about 30 States, is that correct --

MR. CHRISTMAN: I believe that's the -- yes --

MR. HACKBARTH: -- that have that rule. But it doesn't fall on the beneficiary to pay it. It's the provider that --

MR. CHRISTMAN: The provider eats it, yes.

MR. HACKBARTH: They eat it at that point.

DR. CHERNEW: [Off microphone.] So the beneficiary --

MR. HACKBARTH: Right. Was there something --

DR. MARK MILLER: We're squared away.

MR. HACKBARTH: Okay. I wanted to ask a clarifying question about the case-mix change. Could you just remind me, Evan, the estimated impact on rural and hospital-based home health agencies?

MR. CHRISTMAN: Sure.

MR. HACKBARTH: This is a topic that Tom and I talk about a lot and I just wanted to be reminded of the magnitude of that impact.

MR. CHRISTMAN: Okay. So the rural payments go up a little bit, on average, about 2.2 percent, and the hospital-based go up by 7.5 percent.

MR. HACKBARTH: Okay. All right. I think we're ready for round two now, round two comments beginning with Karen and then Scott.

DR. BORMAN: I support the recommendations and I think the one that probably we all struggle with the most is the one related to the copayment, and at least in terms of my own thinking, it's helped me to put the -- because I think we all want to say, let's put this in the perspective of multiple copays, equity of copays, and so on and so forth.

I think perhaps the other perspective that we need to consider in this is that we have been discussing benefit design and the 21st century beneficiary certainly for several years, and we're progressing down that road, but I think it's a somewhat long road. It's likely to be a

continuing road. And it raises the issue of should we not -- are there not topics that we should address in the interim rather than waiting for the ultimate solution.

And I think this is one of the topics where perhaps we should, and the reason that sways me is that in the time that I've been here, every year as we go through the update process, we talk about some fairly eye-popping margins in certain fields compared to certain other fields, and I think that this is one of them. And I think that we -- I'm comfortable with the concept that there are things that deserve more immediate action just as our update process is an immediate annual thought process versus some of the more philosophical, programmatic, more broad-based actions that we take.

And so at least for me, I think that we've talked about home health and the system of home health just as we've talked about other systems and we've reached a time where we're obligated as good fiduciaries to make this recommendation that includes the copayment. I think we all have warm and fuzzy feelings about the very best that home health can be, and I think it's a little bit like flavoring our discussion of hospice, for example. We all have very

deep-felt convictions about what a fine service that can be, about mental health and behavioral treatments and so forth. And sometimes we have to step back a little bit, perhaps, or at least I need to instruct myself to step back from some of those connotations to make a more perhaps detached, intellectually-based judgment.

So short version, I would support the recommendations.

MR. ARMSTRONG: So Karen actually just very articulately made the same arguments I would make. I would just add that I come from a point of view where we have to be very cautious about creating disincentives to invest in services that overall promote better health and lower costs, and home health, I tend to believe, is one of those services. But I think in this case, it is balanced, as Karen said, against margins and other issues that in the near term really warrant a copay and, I think, a very reasonable copay as we're talking about here, not unlike very reasonable copays that are applied to many other services that we really want our patients to get because it does improve health and lower expense trends. In this case, the Medicare program is spending too much on this service

and I think this is a tested approach to mitigating some of those expense trends and I support it.

DR. STUART: I also support the recommendation with some reservations. The lack of research evidence for copays for episode-based services is a concern to me. We don't know what the response is going to be. A hundred-and-fifty dollars, we have heard, is going to be problematic for individuals who are right on the, maybe over the dual eligible threshold. A hundred-and-fifty dollars actually is a lot compared to what an individual would pay under the Part B coinsurance for a single visit. And the consequence of an individual opting not to take home health, which could include up to 60 visits, on the basis of this one decision, I think is something that we need to be cognizant about.

I guess if we were to think about this in the longer term and we include strong language about having a copay, I would also like to see some language that says, okay, if this thing goes into effect, let's make sure that we monitor it so that we can at least have a learning moment and find out what actually happens, because this is not something tried and true. This really is something new.

DR. BAICKER: I'm also focused on recommendation

four and I do like the idea of introducing copays and I like the framing of having the $150 copayment per episode be illustrative, not that we have figured out that's actually the absolutely correct amount, but here's an example that we think might work.

Along those lines, I wonder how sure we are of the per episode copayment, that in some sense, sticking that word up in the recommendation makes it sound like we're very sure that it should be strictly per episode and not some mix of per episode and per visit. Are we really thinking of the $150 per episode as illustrative and the per episode word should come down into the illustration, rather than we're sure about the per episode, we're just not sure about the dollar amount being optimal, and that's a question. It's not that I am uncomfortable with the per episode payment, but I'm not sure how prescriptive we want to be along that one particular dimension versus the others.

And the other clarification is when I first read the phrasing of the dually eligible not being subject to this, at first pass, it makes it seem like Medicare should be picking it up, not Medicaid, just like any other copayment, and then I've understood from the discussion and

more of the detail in the text that we mean it's just like any other copayment. Medicaid picks it up for the dually eligible. I wonder if we can tweak the wording in the recommendation to make that a little more clear, because at first reading, I think people could think that we're treating this copayment as special relative to the others, whereas the principle that we're introducing a copayment somewhere that's kind of parallel to the others is one that we want to emphasize, not obscure.

MR. HACKBARTH: Let me pick up on the first point and, again, think out loud about this. Clearly, there is no definitively right answer as to the appropriate level of the copay. I know of no research existing nor any method of analysis that would get you to a precise right number. There's probably a range of possible numbers. Hopefully, $150 is inside the range.

As Kate noted, the $150 is not in the bold-faced text but rather beneath, and I think that's appropriate given the uncertainty about exactly what the right number is. My gut instinct, however, is that the per episode issue is a bit different. If we were to move that, it would have a more significant effect.

If we have -- neither specify the unit nor the amount, I think the recommendation becomes very abstract and it's sort of, you know, somewhere, somehow, there ought to be some kind of home health copay, and I can readily imagine the situation where Mark or I in a hearing setting or in a briefing setting say, what does this mean? You haven't specified the unit. So I think it would really weaken the impact of the recommendation to take out the per episode piece as well as the number.

Having said that, that is not to deny the issues about is per episode the right way. If I thought, however, that there was some way in a finite period of time we could reach a definitive answer and say to the Congress, oh, we know the right way to do it is per episode or per case and here's the analysis and the calculations to prove that, then I'd say, well, let's hold off and do that and then make the recommendation. I don't think that there is any way to definitively say. I think Bruce is right. We need to do it and test, identify unintended consequences and potentially be prepared to adjust.

So that's my thinking, that this is a reasonable balance. Take out the dollar amount, move it to the text,

but stick with per episode. That was my thinking.

Nancy?

DR. KANE: I was just wondering if there's been any MA plan experience that we could learn from or whether we could suggest a pilot or something that would be, I don't know, less -- don't go whole hog until you kind of have tested a few possibilities. But otherwise, I'm supportive of the idea.

MR. GEORGE MILLER: I agree with Bruce's statement very, very clearly about the copayment. I'm a little troubled, and he has already said it. I an support the recommendations, but I share his concerns.

DR. BERENSON: First, I'm with Karen and Scott on the need to do this and not just wait. This is a benefit that is careening out of control, and so I don't think we have the luxury of just sort of let's do this in the context of an overall assessment. Hopefully, we will succeed at an overall assessment and we can come back to this issue in the context of a broader assessment, but that could be difficult and I just think we need to send a clear -- make a clear statement at this time with the current trends. So I think we have to proceed. I'm not wedded to $150 exactly and

would be happy if we could sort of use that as an illustration.

I am pretty -- I think it makes sense to do an episode-based copayment, and Bruce raises the point about, you know, in some circumstances, it could be substantially more than an office visit copayment, but we have an exception for low-visit episodes, four or fewer. Just like the payment to the provider, there's a different payment mechanism when there are only a couple of visits. So I think you --

MR. HACKBARTH: Is it four, Evan, is the cutoff?

DR. BERENSON: So that's, I mean, and there can be an occasional case, I suppose, when $150 is more than five visit copays, but I think as a general proposition, the payment -- I mean, the concept now is an episode of care. I think it's administratively much simpler to administer a single copayment rather than electing every time.

I'm all for -- I agree with Bruce completely. Let's study the impact of it. But I think we -- I mean, I agree with the Chairman that we have to say something more definitive than we'd like some kind of a copay for some kind of a unit of service. I'm happy to support $150, but if

there's a consensus that we should use that as an illustration rather than a definitive recommendation, I can go that way, too.

MS. UCCELLO: I pretty much agree with everything that's been said, and Bob just said a lot of other things that I was going to say. I'm much more comfortable with an illustrative $150 versus the $300, although I do think, on average, that's going to be less than some other things. But if you have just five, six, or even seven visits at an office, that's still going to be -- the home health copay will be more expensive than that.

I'm not sure -- I'm troubled by that, however, if for those low-visit cases it is just as appropriate to go to the office. So it might not be that big of a deal. But in the end, I support this, especially if the $150 is framed more as an illustration.

MR. HACKBARTH: I just want to pick up on Cori's point. So the beneficiary goes, say, for seven visits. It's $150 and that works out to 20-some-dollars a visit. If that prompts the beneficiary to say, "Oh, I will go to the doctor's office instead," the net effect of that on Medicare spending is to reduce Medicare spending because we're paying

for an episode that's -- what's the average cost?

MR. CHRISTMAN: Three-thousand dollars.

MR. HACKBARTH: Right. So if it has that effect, from the perspective of trying to slow the rate of growth in Medicare spending in this really rapidly growing benefit, that's a good thing.

DR. BERENSON: Although if I could point out, these are supposed to be homebound patients who can't just go rushing off to the doctor's office --

MR. HACKBARTH: Well, that's true, too. That's true, too.

DR. NAYLOR: They're also not getting comparable services. I mean, an ambulatory care service is very distinctly different from home care services, which often include nursing and home health aides. So you might be able to make PT in an office comparable to PT in the home, but you're looking at a very different set of services to a different population.

MR. HACKBARTH: Yes, and that's fair enough. I'm too tied up in my mathematics. It was Cori's, the actuary -

MS. UCCELLO: Throw me under the bus.

[Laughter.]

MR. HACKBARTH: -- triggered that impulse. Mary?

DR. NAYLOR: So I support the recommendations with varying levels of enthusiasm. Strong support for the fraud and abuse recommendation. I like the new set of recommendations, which are placing a premium in 2012 on the home health case-mix.

I was -- my impression earlier was really is there any way, even though these are different, the case-mix and CMS, but the recommendation five around protecting the beneficiaries through sets of strategies, you know, if there's a way that the text could really also encourage that in the next year we think about risk corridors and other strategies to really protect the beneficiaries for an earlier rebasing. I think if we can put in the recommendation around the copay that we will also encourage monitoring as a deliberate part of the recommendation, that would be appropriate.

And the only other comment is, you know, in terms of eye-popping margins, which I think are important, there are eye-popping margins within this sector as well as across these sectors that we need to pay very close attention to going forward.

DR. DEAN: I have several thoughts. On the issue of the freestanding versus hospital-based providers, Glenn and I have talked about this quite a bit. I guess I'm bothered by the reports of, quote, "rural margins" because those data leave out 90 percent of the State of South Dakota. We simply don't have any freestanding providers in the vast portion of the State. They're only in two corners of the State which are the population centers and the rest of the State is simply not included in this analysis, which I understand there's a whole lot of problems with comparing the numbers and all of that, and yet it seems like these are the only facilities that are willing to try to undertake to provide this service and so at least they're situation should be considered. Now, you know, I understand all the accounting challenges and so forth of doing that.

I guess to move on, I'm also a little bothered by the comment that the decline of -- or the closing of some agencies is due to the inadequate payments from other sources. That may well be true. I caution that that came from one source. It's a source that I consider highly credible. But in talking to some of the folks in South Dakota that have dropped home health as a service, they say

just the opposite. They say, we had almost no contribution from other providers and it was totally a Medicare issue and it was related strictly to the fact that we have relatively small numbers of patients and we have to drive a long ways to serve them and we just simply couldn't cover the cost, even though when they did drop the service, it hurt their overall cost report. So they paid a price. They were shifting some costs. They freely admit that. But they were losing so much in the rest of the program that they accepted that because in order to keep the facility going.

I think the bottom line, to get a little broader, I support the recommendations. I think that the rebasing and the case-mix issues are clearly moving in the right directions. They're the things that we need to do. The situations I just referred to are probably special situations that maybe can't be dealt with in the breadth of the program, because overall, I thoroughly agree that the program appears to be out of control. The spending is out of control and we need to restrict it.

I think, to me, the underlying problem is we've got a benefit that just is not well defined and it's especially bothersome to me that -- and I thought Scott's

comment from last meeting really was the issue. This is a very important service when it's focused and done for the right people at the right time. And we haven't been able to -- in a program like Scott's, you folks obviously look at it and decide and make good judgments and make good use of the service.

I guess the piece of data that bothered me the most was the fact that we can't show that people that are receiving the services have any decline in re-hospitalizations, and to me, that is the one thing that this service should accomplish. And if it's not doing that, then we clearly are missing the mark.

So I agree that we need to be cautious about the copay issues, but I wholeheartedly support the idea because if the program hasn't really defined clearly what the need for the service is, hopefully, we can enlist the user in making a judgment about how valuable the service is and they maybe will help us to make that judgment. So we need to be careful about it, but I do think inserting a copay, as long as we're cautious about how we structure that, makes all kinds of good sense.

MS. HANSEN: I do support the overall

recommendations with the same one area of the question of the copays. I've been deliberating this a lot, especially as I've been hearing my colleagues, mainly because I do know that the price barrier could be a reason people don't do this. But I just wanted to just probably explain the contours that I think that whether it's the $150, not codified but just the sense of some figure that is reasonable.

A flip side of looking at that, I know, Evan, we came up with the possibly four visits based on a threshold and whether or not it would take other combinations, like six visits, so that somebody could really get a sense of how helpful that is and that there may be some potential value even though, again, we may not be talking about the $150.

My concern about the benefit careening ahead that has really driven this whole sense of the community copay consideration is the fact that somebody was asking about, say, how Scott might do it in a more managed care environment, and some of you know that this is the environment I lived with with this particular set of population. And what's interesting is -- and when you were asking, I think, Peter, about could we see what managed care

does and is there some comparable, I'd caution that, because having lived through a model where actually we used very little home health but used a lot of home care to help people be stable, and these are technically two defined separate services. Oftentimes it's the home health has a more medical license-driven approach to it, and the other one, if we're maintaining chronicity and keeping people stable, oftentimes people who do home care with supervision can do it, which is a very different price point, as well.

So I just wanted to be saying that what is the ultimate outcome is to help people perhaps be stable if they have a little bit of imbalance and they need to be stabilized and they don't go to the hospital. It's not only this one solution to do it. So when we move toward more episode payments, there are other ways to achieve the outcome that we're looking at rather than looking at the discreetness of this. But that doesn't take away from the concern to make sure that the beneficiary who could benefit appropriately from the service doesn't just find the price itself a barrier but find the incentive of the wellness of being stable as a reason to pay a little bit of money to help maintain that.

So as I said from the onset, I do support this, but I think that fourth recommendation just could have a little bit of given flexibility of consideration.

MS. BEHROOZI: You've pulled together so much information, Evan, and it's clear that a lot of what we respond to is -- I'm going to use an inflammatory word, it'll probably show up in some article somewhere -- but clearly some obscene behavior in certain quarters. So I'm happy that the first recommendation is to really try to get at that.

But I think, then, that we shouldn't keep that as our framework for looking at the rest of the benefit. So I am -- you know, clearly, in my first round comments, I expressed the concern for the good providers that could be whacked by rebasing before there is the revision to the case-mix adjustment. So, I mean, if we could insert the word "immediately" in the recommendation about the case-mix adjustor, I don't know. We don't do the wordsmithing here, but I think that we should, as you suggested, Glenn, that we really should make it clear in the text that we assume that's coming first to protect the good providers.

But similarly, then, when it comes to patients,

when it comes to beneficiaries and driving their behavior, we're looking at an across-the-board, applies equally to everybody regardless of the appropriateness of the home care for that person, the home care benefit for that person, given their condition and given their income level. So I feel like here we're moving in a progressive direction with respect to adjusting how the agencies are paid, focusing on patient characteristics, yet we're ignoring patient characteristics when we're talking about imposing a copay.

So I think that some of those things people have talked about, I think Bruce's point about the $150 or whatever the number being, and Kate sort of supported this, being a per episode cost creates a cliff. It might be a small amount of money compared to what Medicare pays. It might be a small amount of money spread across what ultimately over the next 60 days that person might receive in terms of visits. But $150 is a cliff. There are people, and let's talk for one second more about what low-income is. I say more because I've done this before. You have told us, Evan, before that 50 percent of Medicare beneficiaries make 200 percent of the poverty level or less. That is $20,000.

There are people in New York City -- and I would

like to just note that there's probably no one in the room who's working full time who's making $20,000 or less. So when we say $150 is affordable, I beg you to step outside your own experience a little bit and think about the people in New York City who are making that level of income, or even a little more, who aren't buying a monthly unlimited Metro card because they can't shell out the $100 all at once. They're paying more per ride because they can only afford to do it as they get their weekly paycheck, as they cash their weekly paycheck.

So I think the per episode direction, directive in our recommendation, actually is one of the more troubling ones for me. I think that we should be looking at a copayment here because it would be equitable. It would give us a lever to drive behavior toward appropriate utilization of care. I don't think doing it on an episode basis, on a level of dollars that is way in excess of what's needed to drive behavior. There is evidence out there about what drives elderly patients' behavior. There is a study of the California Medicare Advantage change in copayment for outpatient services experience, and we were talking about changes of $5 there, or $8 or something like that, leading

people to a lower utilization of outpatient care. And those authors found, and I know there's some questioning of this, but that is a study out there -- those authors found that there was then a hospitalization onset. There was a higher utilization of hospitalization.

So to say, oh, $150 sounds like a good number and I'm comfortable with that and it doesn't sound like too much, I think we really ought to be looking at more evidence than just from our subjective point of view or even our view as the payer, as Medicare, what we pay for an episode. We ought to be looking at it more from the point of view of the patient, the characteristics of the patient, and look for a way to -- or encourage the Secretary or somebody to look for a way to set a copay in a way -- or not a copay, set a copayment system that would encourage high-value utilization.

There are other tools that Medicare Advantage plans use. They use prior authorization and denials and things like that because they're looking to encourage appropriate care. I can imagine that there are providers who would be really unhappy that the patients they're trying to serve say, no, I don't want you to serve me because I'm

not going to come up with that $150, typical good providers, whatever. And on the other end of the spectrum, there are providers who would generate more four-visit cases because there's no copayment or would waive the copayment even though they're not supposed to. They would treat it as a bad debt. So I don't know that you get at really encouraging utilization of high-value care by the beneficiaries who need it with a per episode copayment.

I will say that -- the last thing I want to say is everything in the recommendation itself other than the per episode, I would support. I wouldn't support the stuff in the text about arriving at the $150, but for me, this isn't a debate about whether or not there should be a copayment but how we're talking about it. I can't support it.

MR. BUTLER: So my helpful comment is that I support this as it is and I like the idea of advancing the concept of copayment now and not just waiting for the next discussion.

The more nebulous thing that I've been thinking about a lot is, as mentioned earlier in the day, the profile of all the copays, which are reflected in Table 12. But if you even go beyond that, we don't have a very beneficiary-

centric view of this overall, and what do I mean by that? I think it was Kaiser Foundation that caught my attention. In some chart they said, if you're 55 today and you live to 90, you can expect to spend something like in excess of $300,000 on health care above and beyond what Medicare will cover, and you go, whoa. Somebody is going to pay for that or we'll have to change the system.

Similarly, you could take it just on an annual basis, say an 80-year-old. What are the bills that they are looking at? They've got the 25 percent copay on the premium level for Part B. They've got the supplemental, if not covered by their retiree health. They've got over-the-counter prescriptions. They've got a number of things, and if we could kind of look at it from the beneficiaries, what are the choices they're making both at the premium level as well as the, you know, and what is that aggregate financial burden and where -- it will help us -- it would help me a little bit to look a little bit more carefully about ultimately where to place the cost sharing.

And I hate to turn to my economist on my left to make that decision for us --

[Laughter.]

MR. BUTLER: -- but they would know a lot better than me what impact are you going to have on the appropriate care and the appropriate place at the appropriate time and taking the limited dollars that people have and extracting it from them in the right way at the right time. And for those that can't afford it, then where do you get others to support that burden so everybody gets an equal share of what is needed to take care of their problems.

MR. HACKBARTH: Well, before we let Mike address that, I am not an economist, but I think the evidence, including going back to the RAND health insurance experiment, is that copays reduce utilization, but they reduce appropriate care and inappropriate care in roughly equal amounts. They're crude tools, and I think to pretend otherwise is not to be forthcoming about it. And this is one of the reasons why I've always believed in more managed care settings where you can be much more deft and focused in how you try to manage utilization issues and get the right care to the right person at the right time. I think fee-for-service, your tools are limited. They tend to be crude. And so I would be happier if the world would quickly move to more organized and more effective forms of care delivery and

related insurance coverage.

Having said that, that's not going to happen overnight and there is a fee-for-service Medicare program with an, at best, fragmented and too often chaotic delivery system and it's causing problems and very high costs paid by also low-income, hard-working people, paid by -- they're going to fall at the feet of our children and grandchildren. And so we don't have the luxury of only using the perfect tools. I don't pretend to be right and Mitra wrong on this, but I think our arsenal is, regrettably, way more limited and way less targeted than we would like it to be in fee-for-service, given the state of our delivery system. And where you come down on that is a matter of judgment and experience and what not.

But I want to be clear. I don't think these are really well-targeted tools for controlling utilization. I think they're not.

DR. CHERNEW: So, I'll start by saying that I had my little note that was going to be a really rousing and passionate support of all of these recommendations in four-part harmony. But since the comments around the table have pretty much given most of my reasons, I'll skip much of the

details. But I would like to say a few things.

You know, in much of the work that I do, I spend my time trying to figure out how the use of copays can be made less crude, and there's no doubt that, going forward, this would be a better recommendation if we had more information and made it less crude in a whole series of ways. And, of course, I think to the extent that the text reflects that, I think that's wonderful. But I think it has to be clear that the text isn't saying, wait until we can do it better. I think we have to do it. I think we have to monitor it and then we can do it better as we move through a whole series of ways. I think it is the fair thing to do relative to other services. I think that the fraud and abuse, for example, isn't new. We have had a very hard time getting it out. I think copays can be very useful given the geographic variation, for example.

I very much worry that the alternative to something like copays is lower payment rates and I think that has the potential to be a disaster in a number of ways. So I think these types of things that we're talking about actually are needed to preserve the program. From someone whose family has used home care and find the program in many

ways and the people who provide the service to be true Godsends, I think it's important to try and make the program as efficient as possible to support it.

There's a few things that I view -- so apart from my general strong support, there are a few issues that I think I worry about, or at least think are worth mentioning. The first one is I'm worried about what you've done with the duals compared to where our imprimatur was, and I'll explain why. The only advantage of copays is sort of the incentive effect one way or another. It's not -- I would be happy if this was budget neutral. It's not -- the goal is not to just shift more money to the beneficiary away from the program but instead to provide the right incentives. And, of course, if we could do it in a more targeted way, that would be better.

The problem is, as you mentioned in response to my clarifying question, we don't change the incentives for the duals at all, so in effect, all that's happening in that population is we're making the Medicaid program -- or shifting from the Medicare program to the States. And what I worry about is the State Medicaid programs and the States in general are under such financial stress that this will be

an impediment to moving forward overall because of that push-back that you get from the States. We don't want to have to pay this. And if they do have to pay it, they'll do other things for certain populations that I care about that will be worse than any of the things related to this because they're facing this sort of budget constraint.

So I guess I recognize Kate's point about you want the symmetry between this, and I think fairness would dictate some symmetry. But the expedient side of my brain says, you know, we're not going to get any incentive effect for the duals, so all we're really doing is taxing the States. I'm not really comfortable doing that. So I'd be happier if the State Medicaid programs didn't have to pick up the copays where this is. But regardless of what decision you make on that, I'm going to vote for it with both hands. That's just my preference.

The second point I'll make is there's been this question about episode or visit, and I think the theory, like most things in economics, is very clear and ambiguous.

[Laughter.]

DR. CHERNEW: And what I mean by that is, on one hand, the theory -- in a costless world, the theory says you

want to put the copay where you think the waste is, where you think the excess use is, and that in my mind would tend to argue on a per visit basis. It would sort of be more efficient in a number of ways.

On the other hand, as Bob mentioned, I think correctly, there's transaction costs to doing it a bunch of ways. It's very hard if you want to do it on a per visit basis and collect in certain ways. And so I end up being a little ambivalent as to both the size of the copays - I think Mitra's, actually, framework that you want to look in terms of the behavioral response from the perspective of the person's income as opposed to the share of the benefit is the correct framework for thinking about it. And so I'm a little ambivalent about the $150, but I think, ballpark -- you know, if this was just a debate that we had to have about what number to put in the text, I hope we could reserve one way or another to resolve what that number is. I think for practical purposes, doing it per episode probably makes the episode strategy more important, and I agree with you, you'd want to say something a little more concrete.

So in the end, I come down favoring the per

episode approach. I could be convinced otherwise. As long as we monitor and as long as we think about this and revisit it, as we do the general copay stuff, I think having a recommendation of a per episode copay in the ballpark -- I don't know what number Mitra would suggest we pick. I would pick more than ten. A hundred-and-fifty, I think, is good. That's down from where we were before. But I'm comfortable with the way that it's written and I think it's actually crucially important that we send the message that we do have to do this and we have to do this now and we have to do this because we care about the service as opposed to because we don't.

MR. HACKBARTH: Time to vote. So we had a bunch of recommendations here and we'll go through them one by one.

Okay. On recommendation number one, all in favor, please raise your hand.

Any no votes?

Abstentions?

Okay. Recommendation number two, all in favor, raise your hands.

Opposed?

Abstentions?

Number three, all in favor, raise your hands.

Opposed?

Abstentions?

And number four, all in favor, raise your hands.

Opposed?

Abstentions?

Okay. And, Mike, you didn't vote twice, did you?

[Laughter.]

[Off microphone discussion.]

MR. HACKBARTH: Next Carol is going to lead us through skilled nursing facilities.

DR. CARTER: Okay. Today, right now, we're talking about skilled nursing facilities. I wanted to start with a thumbnail sketch of the industry. There are just over 15,000 providers and about 1.6 million, or about 5 percent of beneficiaries, use SNF services every year. Program spending in 2010 topped $26 billion. And just as a reminder, Medicare makes up about 12 percent of a facility's days, but about double that, about 23 percent, of their revenues.

Here's the framework. We should be very familiar

with that at this point. We had talked about all of these findings in December, so I'm just going to summarize them here. Access appears stable for beneficiaries. There's been a steady growth in the number of -- a small increase in the number of providers since 2000 and a steady growth in the number of bed days available. Occupancy rates have declined, indicating that there is phase two admit beneficiaries.

And although there was a small decline in covered days and admissions, this reflects lower hospital use. While most beneficiaries appear to have good access to SNF services, we noted two troubling trends. First, racial minorities have lower admission rates compared to white beneficiaries, and we talked about the possible reasons for this.

Second, the number of SNFs treating medically complex patients continued to decline. And, Jennie, you noted that the concentration could reflect that many facilities don't have the capabilities to furnish complex care, and I incorporated that comment into the chapter.

We noted -- we've long noted the biases of the payment system to furnish rehab therapy and discussed how

some SNFs focus on therapy patients while others may concentrate on more medically complex patients by having, for example, ventilator units.

Bob, you asked about SNFs with high shares of medically complex cases and you wanted to know what share that was. At the 99th percentile, these patients make up 31 percent of those facilities. These facilities were disproportionately rural, non-profit, and hospital-based. And as the chapter discusses, CMS has taken important steps to rebalance payments between therapy and medically complex care, but we think that more still needs to be done.

The Commission's outstanding recommendations to revise the PPS would address some of these disparities by redistributing payments towards patients requiring medically complex care and away from therapy care. And it would also dampen the incentives to furnish therapy services. Based on their mixes of patients, these revisions would raise payments for non-profit SNFs and to hospital-based facilities, and I'll come back to these recommendations at the end of the presentation.

Turning to other indicators, we've examined risk-adjusted community discharge and rehospitalization rates and

have found that quality was unchanged between 2007 and 2008. In terms of access to capital, access was improved over last year and Medicare continues to be a preferred payer.

Comparing payments and costs, the aggregate Medicare margin for free-standing SNFs was 18.1 percent in 2009, indicating that Medicare payments were more than adequate. There continues to be variation in financial performance across location and ownership, with rural facilities having slightly higher margins than urban ones, and for-profits continue to have considerably higher margins than non-profits, though this is the smallest difference that we've seen in a few of the past year. But even for non-profits, they had an aggregate margin of 9.5 percent. And as we've noted before, if our outstanding recommendations were adopted, the disparities in margins would decrease.

Nancy's not here, but I answered her question about whether SNFs with high Medicare margins also have high total margins and what their Medicaid shares look like. This is a table with a lot of figures on it, so I'm going to walk you through it slowly.

We divided facilities into quartiles and those are

the four columns across the top, and we divided them into quartiles by Medicare margin and then looked at several measures. These are all medium values for the quartile. You can see the Medicare margin for the quartile on the first line. And on the second line, you can see the total margins increase across the Medicare margin quartiles.

The bottom quartile SNFs had total margins of .1 percent, while the top quartile SNFs had total margins of 6.9 percent. On the third line, you can see that Medicare share of facility revenues also increase across the quartiles, and this is a function of their shares of intensive therapy days, and that you can see on the next line. Medicare shares of days don't vary very much across the quartiles, and I didn't put that here on the slide.

On the next line, you can see Medicaid share of days, and you can see that there was very little variation in the Medicaid shares. On the bottom two lines, you can see the cost differences and not payment differences really drive the financial performance differences. Payments per day were 8 percent higher across the quartiles, but cost per day varied by more than 30 percent.

We also looked at the efficient providers and to

be in the efficient group, we looked at both cost per day and quality measures. And to be in the efficient group, you had to be in the top third for one measure and not in the bottom third for any of the measures for three years in a row. And almost 850 SNFs met these criteria.

Comparing these SNFs to other SNFs, we found that they had a cost per day that was 10 percent lower after adjusting for differences in case-mix and wages, community discharges that were 29 percent higher, rehospitalization rates that were 16 percent lower, and they had higher Medicare margins, 21.8 percent compared with 17.4 percent.

Looking at their historical trends, efficient SNFs appeared to pursue strategies to both lower their cost growth and to increase their revenues. So it's clear that it's possible to furnish relatively low cost, high quality care and do very well financially.

We project the SNF margin to be 10.9 percent in 2011. The margin goes down because payments were reduced in 2010 to more accurately account for the impact of the case-mix groups that were implemented in 2006, and then in 2011, CMS reduced the update to account for a past forecasting error.

Bruce, you asked about how sensitive this projection was to behavioral assumptions behind it. This projection does not take into account that SNFs can and have shifted the mix of days to high payment groups. If we assume that facilities continue to shift their mix of cases into high payment groups for 2010, but not for 2011, it raises the estimated margin by almost 3 percentage points. This is a reasonable projection because the incentives to shift payments into high -- patients into high payment groups remained the same in 2010 as they were in 2009. So we might assume that the recent historical shifts where patients were grouped would continue.

But in 2011, CMS implemented a host of changes and we don't know how the industry will react to those. And so we didn't assume any shift in where days get classified for 2011. Under this mix of assumptions, the aggregate margin would be 13.6 percent instead of 10.9 percent.

At the December meeting, we talked about the possibility of rebasing payments. When the Commission considered rebasing for home health payments, MedPAC examined changes in costs and visits since the PPS was implemented. Likewise, before rebasing is considered for

SNFs, we would like to consider the changes in costs and practice patterns that shape facilities' costs, and see how these have changed since the base rates were established. And we plan to do this work over the summer.

This leads us to the Chairman's draft recommendation, and it reads, "The Congress should eliminate the update to payment rates for SNFs for fiscal year 2012." Margins are projected to be more than adequate to accommodate expected cost growth and the productivity adjustment. This recommendation would decrease program spending relative to current law by $250 to $700 million for 2012 and by $1 to $5 billion over five years. Spending is lower because current law calls for payments to be updated by the combination of the market basket and a productivity adjustment. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

We view the update as only one tool to help increase the accuracy of Medicare payments. Other recommendations seek to improve the targeting and equity of Medicare's payments. Although CMS has made progress on improving the SNF PPS, more work remains to be done, and we

plan to reprint the following recommendations to revise the PPS.

As I discussed before, if implemented, these changes would redistribute payments, but not affect the level of spending. And second, to establish a quality incentive payment policy so that program payments are tied to beneficiary outcomes. This would also affect the distribution of payments.

These recommendations would narrow the differences in financial performance across facilities and level the playing field between facilities. So we consider them really a package. The update sets the level and these other recommendations are a way of distributing in a better way payments across facilities. And with that, I look forward to your discussion.

MR. HACKBARTH: Okay, thank you, Carol. Let's see, it's Mike's turn to begin clarifying questions. Peter?

MR. BUTLER: So those are kind of stunning results, that one chart that shows it's about the cost per day that is the biggest explanatory variable. Right. The bottom right-hand corner is the $284 number, is the one that gets your attention at the bottom as the reason for the

difference. It's not so much the mix, Medicare or non-Medicare or even the share of intensive therapy days. It's mostly about the cost per day.

So that leads to the more intriguing question, why do they get it so lower? These are labor-intensive institutions, so it must be either the mix of caregivers, the amount they're paying, or the number of them. Do we have any idea why it's $284 versus $325 versus $406?

DR. CARTER: I've looked a little bit at that and that is the work that I plan to do over the summer. We do know that the differences in costs are both on the routine side, which is where the nursing cost would be, and staffing in general, except for admin, and on the ancillary side. So they're higher for both categories -- those are pretty broad buckets, but they are higher for both of those. But that's exactly the work that I want to do over the summer.

MS. BEHROOZI: No.

Ms. HANSEN: That same chart. It would be interesting, Carol, would you be looking -- when you say that there are different things you're going to be looking at relative to this, and I just wonder what the staff turn over rates would be in some of these different facilities

because staff replacements and things like that, and the quality sometimes, has been known to vary when you have a high turn over rate as well.

DR. CARTER: As part of the reform law, facilities are now required to submit staffing data that will allow us to calculate turn over rates, but right now we don't have that data. We would be able to look at staffing levels and staffing mix, but not the turn over. But you're right. Those are consistently related to quality measures.

MR. KUHN: Carol, on Page 13 where the second part of the recommendations. The three that you list there, the add a separate non-therapy ancillary, and the other two, if I remember right, an outlier policy would take an act of Congress. Is that correct?

DR. CARTER: That's right. CMS does not have the authority to do that.

MR. KUHN: But the other two CMS has the authority to do those on their own, and as I recall right, MedPAC first published these recommendations in '08. What's been CMS's general reaction to those first two?

DR. CARTER: They are working on a separate NTA component design. We have talked with them several times

about that, the most recent conversation was in the fall, and they're making progress on that. I don't know if we'll see something in this proposed rule or not. I would say that we haven't made much progress in our conversations with them about the therapy component.

MR. GEORGE MILLER: Yes. Again, thank you for this information. One of the statements made in the chapter was a little bit surprising to me, so if you could bear with me just one second. You said racial minorities make a larger share of medically complex admissions than rehab admissions and some minority beneficiaries may experience delays in being transferred to a SNF and may be placed in a SNF further from home.

So based on that statement, do all beneficiaries who are medically complex have a problem being transferred or is it just minorities have the problem being transferred? It's on Page 16 -- I'm sorry -- Page 10 and 11 on the text in the chapter you sent us.

DR. CARTER: What I found was that African-American beneficiaries made up 10 percent of SNF admissions, but 16 percent of special care admissions and 17 percent of clinically complex. And so, they're disproportionately

represented in the case-mix groups that were disadvantaged by the payment system. And so, I was simply stating that they would be more likely to have delays. But remember, since hospitalization is a prior requirement, they're in a hospital. They're waiting for placement.

MR. HACKBARTH: So all medically complex patients are --

DR. CARTER: Yes. Sorry.

MR. HACKBARTH: -- in that position and may have reduced access to care.

MR. GEORGE MILLER: Right. I just wanted to make sure --

MR. HACKBARTH: Minority patients are a disproportionate share of the medically complex, so the impacts falls. Okay.

MR. GEORGE MILLER: Yeah, I got it.

MR. HACKBARTH: Nancy? Bruce? Scott? Karen?

Round 2 comments. Peter? Mitra? Jennie? Tom? Mary? Cori? Bob? George? Come on, Bruce, you can do it. Scott?

MR. ARMSTRONG: I could make something up.

[Laughter]

MR. HACKBARTH: Karen?

MS. BEHROOZI: So thorough.

MR. HACKBARTH: Yeah, Carol gets the prize --

DR. CARTER: I think they're worn out.

MR. HACKBARTH: -- anticipating and answer questions. There's Kate. Kate, did you have any Round 2 comment? You almost missed the vote.

DR. BAICKER: No.

MR. HACKBARTH: No? No. Okay. You are just in time to vote on the recommendation. All in favor of the recommendation please raise your hands.

Opposed?

Abstentions?

Okay. Thank you, Carol. Well done.

Last for today is inpatient rehab facilities.

Let's see. Christine and Craig are going to do that.

MS. AGUIAR: During this presentation, we will review the adequacy of Medicare payments to inpatient rehabilitation facilities. First provide inpatient rehabilitation services to patients after an injury, illness, or surgery. Medicare fee-for-service is a

principal payer accounting for about 60 percent of IRF cases in 2009 and $6 billion in spending.

During the December meeting, a number of Commissioners asked questions for follow-up. Glenn asked for the number of IRF Medicare patients that are admitted from the community. In 2009, 2.5 percent of IRF Medicare patients were admitted from the community. These patients have to pay the Part A deductible. Also in the December meeting, Ron asked how soon therapy must begin for patients admitted over the weekend. IRFs are required to initiate therapy within 36 hours from midnight of the day of admission, including for patients that are admitted over the weekend. I will address the remaining questions later on during the presentation.

As a reminder, we use the same framework for payment adequacy as the other sectors. This slide reviews our measures of access to care. Overall, our measures suggest that access to IRF care is adequate. In 2009, changes in IRF supply varied by provider category. However, the total number of IRFs remain relatively stable. Occupancy rates were also stable in 2009 at 62.8 percent, which indicates that capacity is adequate to handle current

demand.

The number of rehabilitation beds also stabled in 2009 after declining between 2004 and 2008. Lastly, IRF volume stabilized in 2008 and 2009 after declining since 2004. In 2009, the number of IRF cases increased by 1.5 percent.

Quality of care is another measure of payment adequacy. Between 2004 and 2010, the gain in functional status between admission and discharge increased 3.3 points for all fee-for-service patients. However, over the same time period, functional status at admission lowered. Currently we cannot conclude whether the gain in functional status between admission and discharge is due to an improvement in quality or due to the declining functional status at admission.

PPACA requires IRFs to submit data on quality measures beginning in 2014 and the Secretary must publish the quality measures the IRFs will submit by 2013. This past November, we convened a panel meeting of IRF researchers, clinicians, medical directors, and other key stakeholders to discuss guidance for CMS on selecting which measures to include.

In summary, participants advised that the indirect consequences of the quality measures should be considered. Participants were concerned that access to IRF care could be limited if facilities changed their admission patterns to select patients that they would expect to perform well on the performance measures. However, some panelists suggested that this concern could be lessened by developing condition-specific quality measures or through risk adjustment.

Participants also advised that the quality measures be malleable and able to change as the rehabilitation and medical care provided in IRFs evolves. Participants agreed that both process and outcome measures are important for analyzing IRF quality of care, and they discussed potential definitions and considerations for the measures in the table on the slide.

In addition, participants strongly felt that risk adjustment is necessary. Panelists were also largely in agreement that the IRF-patient assessment instrument is the best tool for CMS to use to collect quality data. The details of the panel discussion are included in your background materials, and I can discuss the panel's conversation on any of the measures in detail if you have

any questions.

Access to capital is another payment adequacy measure. Hospital-based unit have access to capital through their parent institution, and as we heard during this morning's inpatient hospital presentation, hospitals' access to capital appears adequate. In addition, two major national free-standing IRF chains are able to access the capital markets.

Per Peter's request from the December meeting, this graph shows growth in cost-per-case from 2005 through 2009, adjusted for case-mix and wages. In 2005, IRFs were responding to the compliance thresholds that was renewed the previous year, and cost-per-case growth was high for both provider types due to large volume declines.

Between 2005 and 2006, the compliance threshold increased from 50 percent to 60 percent. In 2006, volume continued to decline across both provider types, and case-mix increased at a higher rate than the year before as IRFs adjusted to meet the increase in the compliance threshold to 60 percent.

In 2006, case-mix increased by about 7 percent for hospital-based IRFs and 3 percent for free-standing IRFs,

and after adjusting for case-mix, growth in cost-per-case was lower in 2006 than the previous year for both hospital-based and free-standing IRFs. After 2006, growth in case-mix slowed down across provider groups. Since 2007, hospital-based IRFs adjusted growth in cost-per-case has been similar to overall hospital-adjusted cost growth.

Nancy asked a question during the December meeting about how free-standing IRFs were able to control cost growth. To follow up on Nancy's question, we spoke with representatives of a large free-standing IRF chain. The representatives attribute their cost management to a number of factors.

First, the representatives stated that cost management is the main focus of this chain because the primary service provided in the hospitals is rehabilitation care. The chain has a history of focusing on cost management, and as a result did not need to adjust their cost management strategies in 2008 and 2009 when IRF payments were held at 2007 levels.

Second, within the past two years, the chain acquired an IT system that permits the hospitals to manage staff schedules in real time. Since salaries and benefits

account for approximately 50 percent of the chain's net revenues, the chain heavily focuses on managing the number and mix of staff.

Lastly, the chain builds and designs the hospitals to maximize efficiency. For example, the chain will design hospitals to be one story, to the extent possible, because the use of elevators reduces efficiency.

IRF margins declined between 2008 and 2009, as we see on this slide, but remained a healthy 8.4 percent across the industry. The margin decline in 2009 is expected because 2009 payment rates were frozen at 2007 levels. The difference between the 20.1 percent margins for free-standing facilities and the 0.5 percent margins for hospital-based units in 2009 is likely due to the ability to constrain cost growth, as we saw in the previous slide, and volume.

Hospital-based units in general have lower occupancy rates than free-standing facilities and also tend to be smaller facilities. Almost half of hospital-based IRFs are facilities with 11 to 21 beds; whereas, 50 percent of free-standing IRFs are facilities with 60 beds or more. To follow up on Nancy's question from the December meeting

on total margins, all payer margins for free-standing IRFs have been healthy since 2002, and were 7.6 percent in 2009.

To project the aggregate Medicare margin for 2011, we modeled the following policy changes for 2010 and 2011. Market basket minus .25 percent, as specified in PPACA, for 2010 and 2011; and an adjustment to the outlier threshold in 2011, the CMS estimated, will slightly reduce IRF payments. We estimate that Medicare margins for 2011 will be 8.1 percent.

Overall, on the basis of our analysis, we believe the IRFs could absorb cost increases and continue to provide care with no update to the payments in 2012. The draft recommendation is, "That Congress should eliminate the update to the payment rates for inpatient rehabilitation facilities in fiscal year 2012."

We estimate that this recommendation would decrease federal program spending relative to current law by between $50 and $250 million in 2012, and by less than $1 billion over five years. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressures on some providers, but overall, a

minimal affect on providers' willingness and ability to care for Medicare beneficiaries is expected.

This concludes the presentation. I welcome any questions.

MR. HACKBARTH: Thanks, Christine. Could I ask a question about the table on Page 10? So the hospital-based row struck me. I expected there to be a difference in the level, but there's also a difference in the trend here, a pretty dramatic difference in the trend. Any theories on why the trend is so much more steeply downward for hospital-based?

MS. AGUIAR: We think that it's related to both economies of scale, so in the sense that the hospital-based IRFs do tend to be smaller facilities and do tend to have lower occupancy rates. And so, I think that that could be one factor as well.

MR. HACKBARTH: Well, wouldn't that affect more the level unless they're shrinking in size at a pretty dramatic rate?

MR. LISK: Can I?

MS. AGUIAR: Yes.

MR. LISK: A couple of things. On the free-

standing, you actually saw them reducing costs in 2009, for instance, in terms of their actual, reducing costs even at the same time that payment rates were brought back to 2007 levels. So that's one factor that happened.

In terms of what the underlying cost growth is for hospital-based, we look on a case-mix basis, what cost growth has been in hospitals in general in the more recent period, but it was higher earlier on because of the decline in volume. And they were affected more by declining volume, I believe, with the effect of the threshold rule for cases to compliance threshold.

MS. AGUIAR: Right. I think if you sort of look at this slide, which this again was per Peter's request because in the December meeting, we presented this unadjusted for case-mix and wage index, and I think in this, you can sort of see the story where the free-standing facilities have been able to control cost growth a little bit more.

Both sides, both free-standing and hospital-based, have been impacted by volume declines and also increases in case-mix. But sort of overall, free-standing facilities have had higher CMI case-mix indexes since 2002 and we see,

especially post-2007, that they are able to manage their cost growth a little bit better. Which again, that then led to Nancy's question for us to get some examples of how.

MR. HACKBARTH: Okay.

MR. LISK: And there was actually also for the non-Medicare population in the free-standing, there was actually increases in volume the last two years, I believe.

MR. BUTLER: Because this was mine and I'm into this, but what I remember was that the hospital-based, there were certainly differences in costs because of the economy to scale, but their occupancy didn't shrink by very much. So they went from like 67 to 62 percent, or something like that, so it didn't look like the rate of decline in volume was much different in the two, or the occupancy rates, but they either couldn't manage their costs as well or there's a change in mix that we can't detect. One or the other. And if we don't have the data to suggest that they have a different mix, then we have to conclude that cost management is what did it.

MS. AGUIAR: I think -- and you're right. In the December meeting, we had the slide on occupancy rates and we pulled that out for this presentation. But they declined

between ‘04 and ‘08. Occupancy rates declined by 5.8 percent.

MR. BUTLER: From like 67 to 62, right, or something like that?

MS. AGUIAR: Yeah, from 65 to 60.

MR. BUTLER: And what happened to occupancy rates in the free-standing?

MS. AGUIAR: So 66 to then 60 was the decline for hospital-based. And then for free-standing, it was from about, if you’re rounding up, 72 to 67.

MR. BUTLER: Yeah, so similar rates of decrease in occupancy rate.

MS. AGUIAR: Right.

MR. BUTLER: So now you can say. But if you have economies to begin with, then it’s on a -- I don’t know.

MR. HACKBARTH: Potentially that would a factor if they’re smaller units to begin with and you have the same percentage decline. It would hit harder on a smaller unit with a higher proportion of overhead costs. Okay. Karen, you’re up, clarifying questions.

DR. KANE: Just so I make sure I’m correct, the wage index that we’re referring here to is the same as the

hospital wage index, correct?

MS. AGUIAR: Yes.

DR. BORMAN: Okay.

DR. STUART: This is also an occupancy question. Is the rate of occupancy, is this just a number of beds that are there divided by the number of people over time, or is it staffed occupancy?

MS. AGUIAR: No, it's occupancy in terms of the number of -- let me get you exactly how we calculate that.

DR. STUART: I assume it's the former. I mean, you wouldn't staff a hundred percent of your beds if only 60 percent were --

MR. LISK: It's traditionally staffed beds, but you can have units that they decide that they're only going to use one of the beds in a unit because of contagious disease and things like that, too.

DR. STUART: Well, that raises a question then about whether it's the average occupancy that's really the important thing, or whether it's temporal instability in occupancy. In other words, is the occupancy, average occupancy rate low because you have a lot of fluctuations back and forth that the hospital essentially is unable to

control for?

MS. AGUIAR: I think what your question is, sort of asking us -- I want to make sure that I understand -- is if you're saying, you know, if you have a 1 to 10 or a 10 to 21 bed facility, that sort of any sort of drop in occupancy will hit them more than a 50-plus facility. Is that what you're saying?

DR. STUART: That I understand. I'm just wondering about what the fluctuation in occupancy is. Obviously it's going to have a bigger impact on smaller facilities, but is it also very large in large facilities?

MR. LISK: We really don't know. I mean, we don't have any way of really checking that. I mean, my impression has been it's pretty stable, but I'm not -- but that's just an impression. But even a one-bed change in a ten-bed facility is big.

DR. STUART: No, no, I understand that part. But I'm just thinking, well, if you have claims with claims dates, you should be able to -- and you know what the facility is, you ought to be able to figure out there's a lot of fluctuation.

MS. AGUIAR: Oh, right, exactly. We could

definitely figure it out. We might actually already have that and we just haven't looked at it. So we could get back to you on that.

MR. HACKBARTH: Round 1 clarifying questions? Kate, Nancy, George?

MR. GEORGE MILLER: Yeah, just briefly. In the chapter, and maybe I completely missed it, but I didn't see any demographic information for the patients. Did I miss that?

MS. AGUIAR: No, I did have it in the text box where I was comparing the fee-for-service and Medicare Advantage patients. So that was the section where it would be in, but we did not include that MA/fee-for-service comparison in either the December meeting or in this meeting.

MR. GEORGE MILLER: Text box, okay.

MR. HACKBARTH: Herb?

MR. KUHN: Christine, just a quick question on Slide 7. And the issue of the notion that the IRF-PAI would be the data collection instrument, obviously CMS is continuing the development of the standardized assessment instrument for all post-acute care providers. Do we think

that would be a good data collection tool?

MS. AGUIAR: You mean the Care tool?

MR. KUHN: Yeah.

MS. AGUIAR: That did come up in the discussion, and the way that the panel -- we sort of framed the discussion was, let's just discuss now in the world without the Care tool having yet been implemented because it's still sort of not known, I think, when that tool would be rolled out. And given that the time line for this is fiscal year 2013-2014, the panel were sort of just going into the -- operating in the world where the Care tool would not be available before then. And so, that's why really they were focusing on the IRF-PAI.

MR. KUHN: That makes sense. I guess the concern I would have on a go-forward basis is per our conversation this morning when we were talking about outpatient and trying to come up or begin the process of a site-neutral kind of payment system. There's always been the talk about a site-neutral payment system for post-acute care, and a standardized assessment tool was going to be key. So I understand for the here and now the IRF-PAI would be the useful tool, but we've got to think about transitions as

well.

MS. AGUIAR: Right, exactly, and that did come up and that was something that some of the panelists were supportive of, is using the Care tool and actually we're really looking forward to when that Care tool came out, not just as a data collection method for the IRF-PAI reporting, but also that Care tool, they felt, has more questions that could be used for risk adjustment that are not currently being collected.

DR. CHERNEW: I just have a question about how margins are computed from Slide 10 for the hospitals. This includes a whole series of allocations, right? So of the costs that you would see, how much of it are things that are broad hospital things that are allocated to the IRF? You know, if the IRF went away, it would just get allocated somewhere else. And how much of it is really -- I don't know how to quite say this -- direct IRF spending?

MS. AGUIAR: I'll let Craig answer this question, but I think that my understanding is that there was work done on this in the past few years to check how the hospital-based costs were, in fact, allocating to the IRFs. I think that is something that we do definitely want to

revisit in the future.

MR. LISK: Yeah. In terms of that past research that we did, in terms of looking at the allocation of IRF costs -- and I can't remember all the numbers off the top of my head, unfortunately, but we didn't really see an allocation problem issue. But yes, you're right about some of those costs, if the IRF didn't exist, potentially would be allocated somewhere else because you have that physical space, for instance, that would have to be allocated as well.

But what we do see, if we look at overall Medicare margins for hospitals within IRF, we see that their margin is actually higher. We also see, if we look at the inpatient margin, we actually see that the inpatient margin is higher, a little bit higher for those facilities, too, facilities within IRF compared to facilities without.

DR. CHERNEW: So do you interpret that as facilities that have good margins spend some of it to create an IRF because they're nice, or do you interpret that as the IRF is in some way profitable and it helps them with their margin?

MR. LISK: It could be both.

DR. MARK MILLER: This is a point that has come up a couple of times and Craig and I were talking about this very point. You do see these hospital-based margins and sometimes you're sort of, like, how the hell does this all work and how do you keep going when you have these large margins. Make sure I get this right. In terms of overall margins and inpatient margins, with and without a hospital base, an IRF helps you. A SNF helps you. And a home health is a wash.

So you can either interpret that as people -- and, George, I think you've made this point before where hospital administrators sort -- and, Peter, maybe you have as well -- sort of looks at the bottom line and looks across lines of business, or your other hypothesis. I hadn't really considered that. I'm doing well, so I'm going to offer this service, but it tends to look like it helps overall.

MR. HACKBARTH: Okay. Any others? Let's vote then. Would you put the recommendation up?

That was just Round 1. Excuse me. Round 2? Karen? Scott? Bruce? Kate? Nancy?

DR. KANE: I just have one quick comment about that cost differential, the rate of growth. It's

interesting what they say they do, which is try to manage staff costs. I call that kind of basic. Does that suggest that the hospital-based ones don't do that?

MS. AGUIAR: I would say the way that they explained it to me, and I'm only hesitating because I did ask them sort of as a free-standing facility what are you doing, less what you think -- compared to what hospital-based IRFs would be doing. But what they said to me is this chain in particular has such a focus on cost control and has historically, and the fact that they were able to get this IT system within the past year-and-a-half to two years really helped them because now they could get real-time reports.

So the example they gave me was that they could see what was the staffing structure like for the shift before and that they're able to make changes for the shift then the next day. So they're just able to respond more rapidly than perhaps other facilities that don't have that.

What they did sort of opine about the difference between the hospital-based is -- and again, depending on how big the IRF unit is in a hospital-based, and I think they were talking about the comparisons to much smaller units.

Whereas, the representative that I was speaking to was saying that because they do IRF care, he gets reports every single day. They focus on that all the time. Whereas, perhaps in a hospital -- you know, his counterpart might be more inclined to look at how the operating room is going, the ER room, and looking for less efficiencies within the IRF unit if it's really a small unit.

DR. KANE: So that would suggest that the focus, the fact that they're just totally focused --

MS. AGUIAR: Exactly.

DR. KANE: -- might be the reason they're relatively more efficient.

MS. AGUIAR: Right. The intensity of the focus and then this IT that has really helped them to respond from day to day.

DR. KANE: It's interesting.

DR. NAYLOR: I thought this last set of comments were really helpful in interpreting the reductions in margins and the fact that there are no differences in quality. So I'm very supportive of it.

MS. BEHROOZI: You mentioned it, Christine, and I just wanted to highlight it a little bit, the text box

comparing Medicare Advantage and fee-for-service use, and I realize that it's only the first six months of data, but it seems like there could be a rich trove of information in there, noting that MA plans use IRFs at half the rate, essentially. I'm not saying it quite right, but something along those lines, and it seems like for higher case-mix index patients. I just wondered what else you thought you might be able to divine from this information, what else you're going to be looking at, and whether you can tell whether they're using other substitute services for those other patients.

MS. AGUIAR: That's an excellent point and we presented it right now as a text box and really haven't emphasized it in the public presentations because this is just raw data or raw counts, and I definitely, once we get more of a full year's data, want to be able to look into it more, do some more sophisticated analyses, try to see sort of if we could figure out -- you know, because it seems like they have a shorter length of stay. If you look at it just initially, like we did, a shorter length of stay, it seems like they have a higher case-mix index.

And taking not exactly the same mix of patients,

but they take more stroke patients than you see in sort of fee-for-service. So that definitely raises a lot of questions I definitely want to delve into future for the next cycle and just do a little bit more of a robust analysis.

The limitation to this is, unfortunately, we don't have the MA data on where else those patients would have gone to, because only for the IRFs so far are the IRFs required to report on the MA patients and you don't have that requirement, I don't believe yet, for the other post-acute settings. So that is, unfortunately, a limitation because we can't sort of be able to see, you know, if they're taking, for example, more stroke patients and less hip and knee patients than are in fee-for-service. Well, where are they sending those hip and knee patients to? So that is a limitation of this data.

MS. BEHROOZI: Given the oft-stated desire to be able to look at post-acute care as a whole, can we consider a recommendation that the other types of service have to make the same kind of reporting on Medicare Advantage just to be able to make better use of this data that's being generated in the IRF context?

DR. MARK MILLER: I may be missing the play here, but we should be able to start doing that as the encounter data comes in and, Carlos, on '12 or '13? I can't remember.

MR. ZARABOZO: '12.

DR. MARK MILLER: '12. So it's supposed to start coming in 2012. Before everybody gets wildly excited about that, generally what happens is that the quality of the data improves over time. Some of the first submission can be problematic but, you know, I don't want to say that. Maybe it will be just fine. But in '12 is when it's supposed to come in.

MR. BUTLER: So I'm still not convinced on kind of the focused factory larger enterprise. I think it can be run more efficiently, but the rate -- how things change, I don't really attribute to that. But I'll still support the recommendation because I don't have data to suggest it ought to be something else. But I would give you an interesting observation. The amount of attention that they said, investing in IT to manage labor, well, while we were doing that, we completed our inpatient electronic record, including in our rehab facility so we can follow our stroke patients. So while they were investing in the management of

labor in IT, we delayed our ERP, which is used to manage labor, and put it into the clinical records side. Maybe there isn't the ROI in the short run, but it does say something about -- you know, and that added to those costs of running that unit. I don't know if that's good or not, but it does say something about the silo effect on where you put your dollars. It's just an interesting observation.

MR. HACKBARTH: Can we put the recommendation up? All in favor, please raise your hands.

Opposed?

Abstentions?

Okay, thank you very much. So that concludes our presentations for today. We'll now have a brief public comment period.

[No response]

MR. HACKBARTH: Seeing no commenters, we are adjourned until tomorrow morning at 9:00 a.m.

Commissioners, our dinner meeting begins at 6:00 in the same room where we had lunch.

[Whereupon, at 4:30 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, January 14, 2011.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 14, 2011
9:01 a.m.

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

AGENDA PAGE

P R O C E E D I N G S [9:01 a.m.]

MR. HACKBARTH: Okay, good morning. We have three sessions today--two on updates and then a report on Medicare Advantage, and Dana is going to begin with long-term care hospitals.

* MS. KELLEY: Good morning. I'm going to review our findings on payment adequacy for LTCH services, and then you'll vote on the draft recommendation.

You will recall, of course, that LTCHs furnish care to patients with clinically complex problems who need hospital-level care for extended periods of time. In 2009, about 116,000 Medicare benes - beneficiaries -- had about 131,500 LTCHs days, and Medicare spent about $4.9 billion on this care, 404 LTCHs filed Medicare cost reports in 2009, and Medicare payments to LTCHs were made on a per-discharge basis based on the MS-LTC-DRGs, which are the same groups as those used in the acute inpatient PPS but with relative weights that are specific to LTCH cases.

Before I turn to the summary of our update analysis, I want to note a few changes to the chapter that were made in response to your comments last month. First, as requested, I've included a text box outlining MedPAC's

previous recommendation on the development of patient and facility criteria for LTCHs. You can see that recommendation here.

I've also learned that CMS is planning to issue a proposed rule by September 2011, outlining facility criteria for LTCHs. My understanding is that these criteria will conform to those that were outlined in MMSEA. These include the requirement of a patient screening and review process to determine appropriateness of admission and continued stay at LTCHs. However, it's not clear, to me at any rate, what the basis will be for determining the appropriateness of admission to LTCHs because MMSEA was silent on that.

MMSEA also calls for LTCHs to have a physician on site on a daily basis and a consulting physician on call. So I anticipate that those requirements might be included as well.

We've also included a chapter a map that shows the distribution of LTCHs nationwide. The country looks a little narrow. And thanks go to Matlin Gilman for his creation of this map. Here, you can clearly see the clustering of LTCHs in certain areas of the country, which we discussed last month.

George, you'll find the demographic information you asked for on pages 17 and 18 of the chapter, and you can see here as well that beneficiaries admitted to LTCHs are disproportionately African American. There are a number of reasons why this might be the case:

The higher LTCH use among African Americans might be due to a greater incidence of critical illness among, in this population.

At the same time, studies of ICU patients have found that African Americans are less likely to choose withdrawal from mechanical ventilation and less likely to have do-not-resuscitate orders. So African Americans might, for that reason, be more likely to opt for or be directed to LTCHs.

Researchers have also suggested that the concentration of LTCHs in urban areas could be a factor, and further, as you can see in this slide, a disproportionate number of LTCH users are under 65, a subgroup that is itself more likely to be African American.

You also asked about dual eligibles, and our analysis of beneficiaries admitted to LTCHs in 2009 finds that 40 percent were dually eligible at some point during

the year. Some of these patients may have become dually eligible over the course of a long spell of illness that includes an LTCH stay.

And finally, Nancy, you asked whether there was a trend in physician ownership of LTCHs, and we looked at LTCHs that have opened since 2007 and found that few appear to be physician-owned.

So I'll turn now to our update analysis. First, we assessed beneficiary access, looking at capacity and supply. This slide shows the growth in the number of LTCHs in the U.S. After rising rapidly from the early 1990s until 2005, growth in the number of LTCHs leveled off between 2005 and 2008.

But between 2008 and 2009, as you can see here, there was another uptick in the number of LTCHs, a rise of about 7 percent. This was surprising to some observers because of the moratorium that Congress imposed beginning in July 2007. However, exceptions to the moratorium were made for LTCHs that were already in the construction pipeline or that already certificates of need. So that exception allowed the influx of new facilities that we see here.

Preliminary analysis suggests that far fewer LTCHs

opened in 2010.

The rate of growth in the number of LTCH beds also picked up between 2008 and 2009, and nationwide there were about 27,000 certified LTCH beds in 2009.

Looking at growth in the number of cases per 10,000 fee-for-service beneficiaries, we see a slight increase in the past few years.

So taken together, these trends suggest to us that access to care has been maintained during this period, but as you know, it's difficult to assess access in this setting because it's not clear that all patients treated in LTCHs require that level of care or that LTCHs are always the best place for some of these patients to receive that care.

As you know, LTCHs do not submit quality data to CMS at this time. So we rely on trends in in-facility mortality, mortality within 40 days of discharge and readmission to acute care hospitals to assess gross changes in the quality of care in LTCHs. In 2009, we found that these rates were stable or declining for most of the top 20 diagnoses.

To assess access to capital in the LTCH industry, we looked first at the three largest LTCH chains, which

together own slightly more than half of all LTCHs. These chains are all publically traded. In 2010, they continued with construction of new LTCHs that were already in the pipeline and thus exempt from the moratorium. In addition, these chains acquired other LTCHs and other PAC providers. According to the chains' filings with the SEC, all three have access to revolving credit facilities that they've tapped to finance these acquisitions.

However, smaller LTCH chains and non-chain LTCHs likely don't enjoy that same access to capital that the large chains do. Policymakers' increased scrutiny of LTCHs spending and quality has heightened investor anxiety about the industry in general, and some analysts consider it to be one of the riskiest of the health care provider settings.

Since implementation of the LTCH PPS in 2003, average margins for LTCHs have been fairly robust. Overall, the 2009 margin was 5.7 percent, but margins do vary across different types of LTCHs. Rural LTCHs and non-profit LTCHs have significantly lower margins on average than urban and for-profit LTCHs. Rural and non-profit LTCHs care for a lower volume of patients on average compared with their urban and for-profit counterparts, so that may result in

poorer economies of scale.

For purposes of projecting 2011 margins, we modeled a number of policy changes. We included updates in 2010 and 2011. For both years, the update was the market basket less adjustments for documentation and coding improvements, and the PPACA-mandated reduction for the applicable year. This resulted in a small but positive update for 2010 and an update for 2011 of minus half a percent.

We also made an adjustment for changes to outlier payments in 2011, which we estimate will increased aggregate payments.

All together, these effects will result in somewhat greater growth in provider costs than in aggregate payments for these years. Assuming providers' costs go up at projected market basket levels, we've projected a margin of 4.8 percent in 2011. You'll note that this is a positive margin in spite of the negative update for that year.

So moving on to the draft recommendation you discussed last month, it reads as follows: The Secretary should eliminate the update to the payment rates for long-term care hospitals for rate year 2012.

CMS has historically used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2012 will produce savings relative to the market basket. We don't anticipate any adverse impact on beneficiaries or on providers or on providers' willingness to care for beneficiaries.

So before I turn it over to you, I'll just remind you that PPACA requires CMS to implement a pay-for-reporting program for LTCHs by October 2013.

Our draft chapter includes a summary of the findings from our recent panel discussion on quality measurements in LTCHs. We convened this panel to get some sense of what LTCH-specific quality measures might be available now or with further development. Our hope is that the information we learned will be useful to CMS as it moves forward with quality measures.

Our panel suggested that CMS begin with a starter set of measures, building on those that LTCHs are already using for internal quality monitoring, and these include the measures that are listed here.

Panelists also discussed the issue of risk adjustment of quality measures in LTCHs. There was

agreement that risk adjustment was generally not appropriate for patient safety measures as long as a present-on-admission indicator was used.

And panelists agreed that risk adjustment was necessary for outcomes measures, but the consensus was that risk varies less in LTCHs than in other settings. Many in the group argued that the issue of risk adjustment should be an impediment to moving forward as quickly as possible.

Regarding data collection, the panelists generally agreed that CMS's starter set of measures should be ones that can be collected from administrative data until a common assessment tool is available.

Our draft chapter also notes that a pay-for-reporting program is just a first step and urges the Congress to move as quickly as possible to public reporting and a pay-for-performance program. We also encourage CMS to be mindful of the measures that are already being used in other post-acute care settings and to strive, when feasible and appropriate, to replicate those measures in the LTCH quality measurement set, so that policymakers are able to compare quality of care and patient outcomes across the post-acute care spectrum.

So that concludes my presentation. I'll turn it back to the recommendation, and I'm happy to answer any questions.

MR. HACKBARTH: Thank you, Dana. Let me ask a clarifying question. At the outset, you said that CMS is planning a proposed rule for the fall, covering the facility criteria, I think you said.

MS. KELLEY: That's right.

MR. HACKBARTH: It caught my ear that there was no mention of patient criteria. Could you just elaborate?

MS. KELLEY: CMS was not able to give me a great deal of detail because things are still in a draft form at this time. What I was told is that the criteria will be facility criteria, and it will follow closely what was -- what's the word I'm looking for? What was in MMSEA. And so as I spoke to you before, MMSEA requires the review of patient appropriateness of admission and continued stay, and also to have some physician presence in the facility.

So my -- the sense I got was that these will be --

MR. HACKBARTH: They're sort of combining the two under the heading.

MS. KELLEY: Yes, and that it will be more of a

minimum level of criteria rather than a high bar -- that was the sense that I got. That's my interpretation of what I was told.

MR. HACKBARTH: So round one clarifying questions, Mike, Peter, Mitra, Tom.

Any clarifying questions?

Herb.

MR. KUHN: Just one quick question, on page 6 of the presentation, on the growth, on the access and growth, those additional facilities that we saw continuing to come through the system, were they hospital-within-a-hospital facilities or were they free-standing or is there any indication kind of where the growth has been?

MS. KELLEY: We've had -- historically, we've had some difficulty distinguishing between hospitals within hospitals and freestanding facilities. It's not always precisely clear what a facility's status is, which is why we've stopped reporting the information separately for those types of providers. But my sense is, having looked at the data pretty closely, that these are predominantly freestanding facilities. The payment policy regulations that have been put in place over the last few years favor

freestanding facilities in general over hospitals within hospitals, particularly given the 25 percent rule.

MR. HACKBARTH: George.

MR. GEORGE MILLER: Yeah, I don't know if you -- first off, thank you for this report and also the demographic information. I really appreciate that.

And I don't know if you can answer this question, but in dealing with the hospitals that are considered efficient providers is there a relationship with the efficient hospitals, whether they have a LTCH in their community versus those who may not? Is there a relationship of them being able to move patients out of their facility?

MS. KELLEY: You mean efficient acute care hospitals?

MR. GEORGE MILLER: Acute care hospitals, correct. I'm sorry. Acute care hospitals.

MS. KELLEY: I don't think we've seen such a relationship, but I -- is Jeff here? Do you?

DR. MARK MILLER: [Off microphone.] This is on the effect of an LTCH?

MR. GEORGE MILLER: Yes, of an LTCH on acute care hospital.

DR. MARK MILLER: Yeah, and I think the way -- Craig?

You'll remember the conversation we had yesterday, and Craig, this is your period to get engaged.

So the conversation yesterday was when you have a hospital-based IRF and SNF, it helps the bottom line. When you have a hospital-based home health, it's a wash on the bottom line for the hospital.

What I think is we don't do this, have the same kind of calculation for LTCH because even when you're hospital-based you're basically a separate entity. Okay?

MR. LISK: [Off microphone.] Yes.

DR. MARK MILLER:

So in a sense, even if an LTCH is tucked inside this, it's not part of the overall cost report and cost structure.

Now it doesn't mean your question could go to a next level and say well, just tell me what the correlation is.

MR. GEORGE MILLER: Right.

DR. MARK MILLER: And I'm not sure we've done that.

MR. GEORGE MILLER: Okay. All right. Thank you.

DR. MARK MILLER: But it's not embedded in quite the same way that the other.

MR. GEORGE MILLER: I'm sure.

DR. BAICKER: I thought there was an extra question in what George was saying. It's the presence of an LTCH in the facility.

MR. GEORGE MILLER: Right, in the area.

DR. BAICKER: Allow a hospital to send people over there and make the hospital more efficient --

MR. GEORGE MILLER: Correct.

DR. BAICKER: -- because they've got a place to offload those people even if it's not --

DR. MARK MILLER: [Inaudible.]

MR. GEORGE MILLER: Right, right.

DR. MARK MILLER: And I don't know. Let us recollect our thoughts because as I remember a few years back --

MS. KELLEY: We have danced around this in the past.

DR. MARK MILLER: Yeah. We did some analysis.

MS. KELLEY: I'm sorry. We did some very careful

--

DR. MARK MILLER: It may have been qualitative analysis.

[Laughter.]

MS. KELLEY: I'm sure it was detailed quantitative work.

DR. MARK MILLER: Or a vignette. But let us collect our thoughts on this.

MS. KELLEY: Yes.

MR. HACKBARTH: On the first issue, the referrals from the host hospital, there's the restriction on the percentage of the admissions that can come from.

MS. KELLEY: Well, technically speaking, yes, although that was one, that was part of the relief that MMSEA provided to LTCHs -- was that the sort of -- the rolling back of the 25 percent rule that had been being phased in. So it has a minimal effect at this time.

MR. HACKBARTH: Okay. All right. Nancy, did you --

DR. KANE: Just a question about my question about physician ownership, what's the sources of data for that and how comfortable are you with it?

MS. KELLEY: This is a small industry. So I really can just look at every single provider that opened between 2007 and 2010. And I, you know, can look into some background information and make -- it is in some respects sometimes a guesstimate. Sometimes it's very clear it's a select facility or it's a kindred facility. You know, one of the major chains.

So I'm not 100 percent certain, but I'm fairly comfortable. I'm quite comfortable, fairly certain with that estimate.

DR. KANE: The kindreds don't do any kind of joint venture ownership within these --

MS. KELLEY: Not to my knowledge. No, they do not.

MR. HACKBARTH: Questions?

Scott, Karen.

DR. BORMAN: In looking at the map and thinking about this and my own personal encounters with LTCH, and then I'm concerned about overlap issue with the acute care hospitals that it facilitates. On the other hand, I think my own personal experience is with an institution that was very pressured as being really the court of last resort for

a state, or for a part of a state.

And I think that, and by offloading by these patients earlier it enables them to deliver more care that's mission-based.

And I'm not sure exactly how we could potentially get at that, but that might link up, for example, level one trauma centers. It might in fact be a way to just sort of biopsy that as some future data point consideration.

The other thing is that in the materials you had the statistic about the percentage, the mortality within 30 days of discharge from an LTCH, and it was quite high as I recall, and certainly that relates to the gravity of the illness of these patients, and whatever. But do we have any way in some future work to tease out -- or maybe it should be part of thinking about what is reported going forward, whether that those are primarily due to decisions by patients or families not to seek additional care versus this is just a consequence, a health consequence if you will, because I think as we think about interventions at the end of life we certainly want to meet everyone's needs as best we can and to do it with dignity and respect for what they may or may not want.

And so just as we think about these criteria, particularly for these kinds of places where this event rate is so high within 30 days, it might be something worth thinking about, going forward.

DR. MARK MILLER: I wanted to follow up on Glenn's question and just do this carefully. So in talking about the patient criteria, and then it's facility criteria, but then as you went through the legislative language you were saying but it refers to the notion of having a patient assessment instrument.

MS. KELLEY: Or some sort of criteria by which to assess the patients.

DR. MARK MILLER: Yes. So in some ways you could sort of look at that as saying okay, so there's patient criteria. Or alternatively, you could look at it as much more low bar, to pick up where you were, that says the facility just has to have a patient assessment instrument. And that could look very different from facility to facility?

MS. KELLEY: I think yes.

DR. MARK MILLER: That's a possible?

MS. KELLEY: I think that's -- I really don't know

sort of where they're headed. They do have some -- there is some patient review that goes on now.

DR. MARK MILLER: As I recall, when we visited the facilities they talked to us about how they did it, and it was very different from facility to facility.

MS. KELLEY: Right. So you know. It doesn't require assessment using a particular tool or a particular -- the law doesn't, or a particular standard. So it's not clear to me what CMS will use as part of that requirement.

DR. MARK MILLER: What I'm trying to convey is -- and I think your line of questioning was headed down this road -- we could still have a situation where the patient assessment side of things, of do you need this level of care, is still pretty wide open even though there is facility characteristic, or requirements. Right?

MS. KELLEY: You know, it's possible. I think -- the industry, I think, feels that they're subject to some of this review already and that it's become increasingly stringent, although my understanding is that upon review of these, after denial when there's -- when they file an appeal and go back at it, that generally patients, a patient admission to an LTCH is approved. So I don't know in

practice how much it has affected, at the end of the day, the admission of patients to LTCHs.

So I really am not -- I really can't say sort of how stringent this will be.

DR. MARK MILLER: [Off microphone.] That's all I was asking.

MS. KELLEY: Okay.

MR. HACKBARTH: One last clarifying question, Dana. Could you put up the slide 10 with the margins?

So when you were talking about the disparity between urban and rural, you seemed to hypothesize that one potential explanation might be differences in volume?

MS. KELLEY: Yes, the rural facilities tend to be much smaller.

MR. HACKBARTH: Yeah.

MS. KELLEY: Quite a bit smaller.

MR. HACKBARTH: Have we looked at the relationship between volume and cost in a systematic way?

MS. KELLEY: We have looked at the facilities with the highest and the lowest margins, and described characteristics of those facilities, and the highest margin LTCHs are quite a bit larger, not just their Medicare

patients but overall, than the lowest margin.

MR. HACKBARTH: So in other contexts, we have recommended low volume adjustments. Is that something that we should be considering for --

MS. KELLEY: We have not ever really discussed that in this setting. I think if we were to think about that one complicating factor would be our consideration of whether we think low volume facilities can provide the same level of quality that larger centers can in terms of their experience dealing with certain types of patients. So I think that would have to be carefully parsed out. Until we have good quality information, I think it would be a difficult thing to look at.

MR. HACKBARTH: Yeah. It also occurs to me that it's a little bit different here than perhaps in the acute care hospital context. In the acute care hospital context, this is sort of a core element of the care delivery system in every community. And you know there are some small communities where you're going to have small hospitals, and you need to appropriately pay, given the -

MS. KELLEY: You need to maintain some level of hospital care in the community.

MR. HACKBARTH: Given that there are a lot of communities that seem to do just fine without LTCHs at all, having a low adjustment rate may not be necessary or appropriate there.

MS. KELLEY: And we've also talked about a model of a referral center type of model in this setting too.

MR. HACKBARTH: Yeah.

MS. KELLEY: So it would have to be weighed very carefully, I think.

MR. HACKBARTH: Thank you.

MR. KUHN: On that point, if I could just ask, since we are doing this rural report that's part of ACA, and I suspect this issue has come up when staff has been out on some of the field visits -- Mark, maybe you can tell us -- is this something we'll hear more about, the LTCH component of rural care?

DR. MARK MILLER: I have to say to date, and I'll take any kind of redirect on this. To date, LTCH specifically has not been a big factor that has come up. I think that in addition to these things being small, there's not tons of them out in general and out in rural areas.

MS. KELLEY: No.

DR. MARK MILLER: The notion of kind of low volume and how I cover my fixed costs, that certainly is a thread that comes up in the -- you know, more broadly for a hospital, yeah. But at least in my travels and actually, you know, travels -- I'm getting nods over here. This specifically has not come up.

MS. KELLEY: There are only about 30 rural LTCHs in rural areas. We are trying, looking at -- as part of the rural report, we are looking at beneficiaries' use of LTCH services and whether the benes are rural and traveling to urban facilities. So we'll have a little bit of information about whether there are rural patients who receive this care even if they don't have an LTCH.

MR. KUHN: So we'll have better patient origin information and where they go.

MS. KELLEY: Yes.

MR. KUHN: Okay.

MR. HACKBARTH: Okay, round two comments?

Mike, and then Peter.

DR. CHERNEW: We talk periodically about the silos across payments, and it's obviously, as many people have said before, nowhere more clear than in this basic post-

acute end-of-life area. And I think there's a lot of things about this particular LTCH setting that suggests that, not as part of the payment portion but as part of other work, we could use it as an example of issues.

So for example, George's question which I liked very much, about the how the presence of an LTCH affects other facilities, but there's also a question about instead of looking at it from a facility perspective, look at it from a type of patient perspective. It's sort of what Herb was saying, and I think Karen alluded to this, which is for types of patients that get care different ways.

We care a lot about quality. The quality measures are hard, but not just the quality in the LTCH. But what's the quality for those types of patients if they had ended up not going into an LTCH?

And the beginning of this chapter talks a bit about this concern that folks had about costs and you get paid for the acute care stay, then the LTCH gets paid. There could be potentially some double payment because of the way that works. But we don't see across the spectrum for patients that are likely to go to an LTCH, or might be candidates, what is their costs compared to the costs of

patients that didn't.

And the geographic variation in the presence of LTCHs gives you -- the researcher in me thinks well, wow, if I had time to really do research, but luckily there's a lot of really good people here who could maybe investigate, if you could identify sort of a type of patient. You don't have to know for sure the patient would have gone to an LTCH, but just the presence of an LTCH.

Even the growth, the numbers that Dana showed suggests there was almost a three-fold growth in the availability of LTCHs, surprisingly concentrated for most models. But the cases pretend thousands stayed about the same, suggesting the size.

So there's something going on that could be exploited, that might be useful for LTCHs, but it's also useful for thinking about this across silos. It's also useful for thinking about bundling.

So in a nutshell, I support the recommendation. I have a few minor things on the chapter like Table 3 says Medicare spending, but it's really LTCH Medicare spending per beneficiary. And so this sort of broadening to focus on the patient population I think is very useful, but overall I

think it's very good, and I support the recommendation.

MS. KELLEY: The Commission has done work in the past looking at particular types of patients and how much the costs that they generated if they went to an LTCH versus not, and that's information I can -- background information I can include too.

DR. CHERNEW: I think that's useful, but that's very hard to know because of the switching. But it's really areas -- patients that are that type --

MS. KELLEY: Yes.

DR. CHERNEW: -- in the areas that have a lot of LTCHs versus patients of that type in areas that don't.

MS. KELLEY: Yes.

DR. MARK MILLER: [Inaudible] -- too, the probability of using these facilities and that type.

MS. KELLEY: Yes.

DR. MARK MILLER: There is some stuff that we can pull back up from previous work and either put in the chapter or give to you specifically.

And I still think there's more to your question and more to be done. Don't -- this isn't dismissive at all, but at least --

DR. CHERNEW: [Off microphone.] I don't mind being dismissed.

DR. MARK MILLER: No, no, it usually doesn't work out for me.

[Laughter.]

DR. MARK MILLER: But I mean there's a platform there that you could even jump from some things that we've already done.

DR. CHERNEW: And does Scott use -- do you use LTCHs, Scott?

MR. ARMSTRONG: Very, very little. I mean one of the questions related to your points, Mike, was I wonder what the LTCH use in MA plans would look like and what we know about that too.

MS. KELLEY: A couple, I guess it was two years ago now I spoke with a number of MA plans about their use of LTCHs, and the general sense that I was given was that they don't use them very often, but that for particular kinds of patients they do find LTCHs to be useful. And so there is a smaller share of their patients than in fee-for-service perhaps that do use LTCHs, but in general their experience was that patients that stayed a little bit longer in the

acute care hospital could then go to a SNF, and that seemed to be the common theme among the plans that I spoke with.

MR. BUTLER: Two comments. One, you said that there are 30 or so rural. Actually, in the chapter, it says there are only 21, which is pretty small.

MS. KELLEY: I'm sorry I misspoke. The chapter is correct.

MR. BUTLER: So I'm not sure you can draw a lot of conclusions from 21 out of 400 or so.

A related comment to Mike's is I was thinking about how to understand both regional variation as well as episode-of-care variation better. We used to look at lot at days per thousand in the managed care world, and I'm wondering rather than just -- and I know Carol has shown us work on dollars in each of the post-acute care sectors. It would be kind of interesting to look at days per thousand in each of the sectors like acute care, LTCHs, SNF, et cetera, because it would get at the utilization versus, you know, the rate per payment.

And if there were patterns either within a geography or across episodes that showed differences, it might be a different lens to kind of understand this

tradeoff between beds in the various options that we have.

DR. DEAN: I guess I would just support the questions that Mike raised. It just seems to me that even looking at quality measures in an isolated way, it doesn't really answer the questions that we need to have answered. We need to look at quality measures for a particular condition in different settings and then try to decide, you know, what is the best approach.

And it looks like since there's such a difference in variation it might be reasonably easy to do because there are certainly some areas where this service is not available and some areas where it's very available. It just seems like it's crying out to decide. We have a model, and we don't really know exactly where it fits and that it's -- there would be -- I know.

I mean I understand you said there's some of that data, but I think we really need to understand it in a much more sophisticated way for us to make any reasonable recommendations about whether we really support and encourage this model or not.

MR. HACKBARTH: Would you put the recommendation up? Okay, all in favor of the recommendation, please raise

your hand.

Opposed?

Abstentions?

Okay, well done, Dana. Thank you.

Next is hospice. Okay, Kim?

MS. NEUMAN: Good morning. I'm going to recap the hospice data we discussed at the December meeting. At that meeting, a couple Commissioners had questions and I'm going to address those as we go through the materials.

So to start with some quick background, as you know, hospice provides palliative and supportive services to terminally ill Medicare beneficiaries who choose to enroll. In 2009, over one million beneficiaries received hospice services, including 42 percent of Medicare decedents, and Medicare spending was $12 billion.

So to review the trends in the data, the number of hospices has grown throughout the decade, growing 50 percent in total over the 2000 to 2009 period, driven by growth and for-profit providers. Hospice use among Medicare decedents has also grown substantially, reaching 42 percent in 2009, up from 40 percent in 2008, and 23 percent in 2000.

Through 2008, hospice use grew among all racial

and ethnic groups and in rural and urban areas. Use continued to grow in 2009 for almost all of these groups. Herb, at the December meeting, you mentioned that some states experienced rapid growth in provider supply and asked whether states that experienced less rapid growth in providers were seeing growth in hospice use.

The increase in hospice use is broad-based. Between 2005 and 2009, all states experienced an overall increase in hospice use among Medicare decedents. Some of the states that experienced the greatest increase in hospice use among decedents were ones that had modest or no growth in the supply of providers.

This next chart shows the growth in hospice spending, number of users, and length of stay. In the first line, you see that Medicare hospice spending grew substantially throughout the decade, with growth in the most recent year being 7 percent. This growth is primarily driven by an increase in the number of hospice users, line 2, and growth in average length of stay, the last line. The increase in average length of stay reflects an increase in length of stay for patients with the longest stays.

In terms of quality, we are not able to make an

assessment of hospice quality because publicly available quality data covering all hospices are not available. PPACA will change this. It requires CMS to publish quality measures in 2012, and in fiscal year 2014, hospices will face a 2 percentage point reduction in their annual update if they fail to report quality data.

As you know, hospice is less capital intensive than some other provider types. But that said, access to capital appears adequate. We continue to see entry of free-standing hospices, mostly for-profits, but also non-profits. Provider based hospices have access to capital through their parent organizations.

So turning to margins, the aggregate Medicare margin in 2008 was 5.1 percent, down from 5.8 percent in 2007. If we look at margins by provider characteristics, we see free-standing hospices having higher margins than home health based and hospital-based hospices, partly because of the allocation of overhead from the parent provider. If provider-based hospices had overhead cost structures similar to free-standing hospices, their margins would be 8 to 11 percentage points higher.

For-profit hospices have higher margins than non-

profits. Urban hospices have higher margins than rurals. Margins are higher for hospices with longer stays and for hospices with more patients in nursing facilities and assisted living facilities.

And as you'll recall, our methodology for calculating margins involves the following. We do not count overpayments to above-cap hospices as revenues in the margin calculation. We also exclude non-reimbursable costs from our margin calculation, consistent with our methodology in other sectors. This means we exclude bereavement costs, which if included would reduce the aggregate margin by at most 1.5 percentage points. We also exclude non-reimbursable volunteer costs, which if included would reduce the aggregate margin by 0.3 percentage points.

Mitra, you asked at the December meeting for additional information on the volunteer requirement. We've added that to the chapter and I'd be happy to du it on question. So just to review, our margin projection for 2011 is 4.2 percent. It takes into account full market basket updates for 2009 to 2011, a reduction in the wage index budget neutrality adjustment in 2010 and 2011 amounting to about 1 percentage point decrease, additional wage index

changes, and additional costs in 2011 for the face to face visit requirement for recertification of long stay patients.

All that taken together gives us our 2011 margin projection. Looking forward to 2012, payments will be reduced an additional 0.6 percentage points in 2012 due to the continued phase-out of the wage index budget neutrality adjustment.

So, in summary, the supply of providers continues to grow, driven by for-profit hospices. Number of hospice users increased. Length of stay for the longest stays continues to grow. Access to capital appears adequate. And the 2008 margin is 5.1 percent, with the 2011 margin projection being 4.2 percent.

In light of all that, the draft recommendation reads, "That Congress should update the payment rates for hospice for fiscal year 2012 by 1 percent." This draft recommendation would decrease federal spending by between $50 and $250 million over one year and by less than $1 billion over five years.

We do not expect the recommendation to have an adverse impact on beneficiaries' access to care or providers' willingness or ability to serve Medicare

beneficiaries. And as you know, this recommendation affects aggregate spending, not the distribution of spending across providers.

In March 2009, the Commission recommended that the hospice payment system be revised to better align payments with the level of effort involved in providing services throughout a hospice episode. This is the U-shaped curve. This change would make the payment system more neutral toward length of stay, rather than favoring long stays as it currently does. It also has the effect of changing the distribution of payments across providers. Overall, it would increase revenues to provider-based, non-profit, and rural hospices, and decrease revenues to others.

We plan to re-run this recommendation in the March chapter because PPACA gives CMS the authority to revise the hospice payment system in 2014 or later, but gives them discretion on the structure of that system.

We also plan to re-run a recommendation from March 2009 for more OIG scrutiny of a number of issues such as nursing home/hospice relationships and unusual utilization patterns among some hospices regardless of patient location. Since many but not all aspects of the recommendation are

under study, we plan to reprint the recommendation.

So that concludes my presentation. I look forward to your discussion and any questions.

MR. HACKBARTH: Thank you, Kim. I need a reminder about the March projections. Could you put up Slide 10 for a second? So we are modeling the 2011 margin. Now, I was thinking that our convention, our rule was that what we do is also take into account policy changes scheduled for the fiscal year in question, in this case 2012. So we know that certain things are going to happen in 2012. In this instance, it's the next step in the reduction in the wage index budget neutrality.

As I interpret what you have on Slide 10, we've included the reductions for 2010 and '11, but not the one that's scheduled for the fiscal year in question, 2012.

DR. MARK MILLER: And some of what's been -- all of that information has been reported in each of the presentations and in the chapters. Some of what has gone on is, for example, in the hospital world, there's some large changes like the new IT dollars and there was another major change.

And so, what we've done is estimated through '11

and then tried to report out what possible effects are, quantifying them in the cases where we can, which in Kim's case, she has the wage index change. That's very quantifiable. And then in the hospital discussions, if you remember, last month we said there's some things happening in '12, big blocky dollars that could move the needle around a lot. And here is as much information as we have.

So as a convention, we've been kind of going through '11 and saying, "This is what we understand is going to happen in '12." In some instances, Kim's, we can quantify it fairly precisely. Other instances, the hospital world, we had some big kind of movements.

MR. HACKBARTH: But I am correct in understanding that the 4.2 percent does not include the effect of the 2012 budget neutrality adjustment?

DR. MARK MILLER: It does not.

MR. HACKBARTH: And the magnitude of that is?

MS. NEUMAN: 0.6 percentage points.

DR. MARK MILLER: I'm sorry. I didn't realize your question was that simple.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: I didn't mean to get into all

that.

MR. HACKBARTH: So Karen, it's your turn. Start any clarifying questions. Scott? Bruce? Kate? Nancy?

DR. KANE: Do hospices also have relationships with LTCHs? I'm just noticing that the progression of our post-acute sector presentation seems to go closer and closer and closer to end of life. I'm just wondering. I guess, when you look at patients sort of considering -- I mean, just kind of put the hospice in the LTCH conversation together a little bit and say, is there anything going on, and how do people make the decision between the two? Is it a very different patient mix diagnostically that goes -- is there any relationship between LTCH and hospice?

DR. MARK MILLER: I didn't want to turn it on until I was sure I was going to say something. Okay. Here's one thing. I think the most direct answer, and again, I'm looking for a redirect. We haven't done the last thing you said, which is tell us the case-mix of the patients who go here versus here. I don't believe anybody has done that on the staff so that we could very much quantify that.

A few years back we did a lot of work on LTCHs and

went out and visited LTCHs and talked to the medical directors and them and sort of what happens. It's very interesting because there were several conversations that I ended up being part of with medical directors where there is this, you know, should you be here in an LTCH or has all, you know, at this point.

And you ran into the usual situations where it's difficult to have -- you know, the physicians, sort of, it's difficult to have that conversation with the family and I'm not sure I wanted to do it, and that some families, even when sort of, you know, you could either go to an LTCH or you could begin to start thinking about a hospice tract. Some families are no, you know, I want the LTCH.

And some medical directors, being very direct, in saying, "I'm going to put this person back in" -- I don't want to say on their feet, but sometimes, you know, for a few weeks, but they're either going to be back here or they're going to be going to a hospice. So this is that tough conversation that, you know, I think, as a society, we all kind of struggle with.

It came up repeatedly when we were talking to the LTCHs. But I don't think there's any formalized

relationship to sort of try and answer your question and we have never said, “What is the case-mix of the two patients that tend to sort themselves.” I think there’s a lot of family, you know, care choice decisions that drive those choices.

DR. KANE: Maybe --

DR. MARK MILLER: Is there anything else I should --

DR. KANE: Maybe this belongs back in the LTCH discussion, but in thinking about facility and patient criteria for both them and hospice, since I think there is that choice that families are making, that that choice should be made clear. You know, how do you make sure that the potentially rehabilitatable or, you know, the patient is really going to the LTCH to start to get better, that that conversation is made clear.

I mean, I’m just trying to go back to what kind of criteria are people using to make those decisions and are they getting those conversations. I know this is not a good topic, but are they getting the kind of conversations they need to be sure that people really understand what they’re doing and what their options are?

Maybe that should be into the criteria discussion for the LTCH and the hospice, because I think hospice has the same problem on the other side. They've got people who might be better off in a long-term care or SNF or even LTCH, I don't know.

It does look like we're having a problem of proper allocation of people to matching to the care and I don't know if that should be -- maybe this is not the right place to start this, but we don't usually look at the whole post-acute sector in any one setting except for in these update meetings.

But should there be, as part of the criteria, for getting in these facilities that there is a required counseling session about what are the options and what are the likely outcomes of each -- anyway, I'll stop there.

But I just find these discussions where the problem of LTCHs having people who might not be appropriate and then hospice having these people who stay away too long and probably aren't appropriate either, that there's something terribly wrong in the way people are being allocated to these different models of post-acute care.

DR. DEAN: Or you have the hospices with large

numbers of live discharges.

[Off microphone discussion]

DR. KANE: There are some conversations that's just not happening here that needs and I'm wondering, maybe even in talking about LTCH patients, criteria or there should be a similar conversation around hospice patient criteria and they should all be linked, and maybe the conversation should be more standardized than it is today.

MR. HACKBARTH: Other clarifying questions? George? Herb? Bob?

DR. BERENSON: Kim, go to Slide 4, please. At a previous meeting, probably the last one, I raised the issue about the medians and in text you addressed it. I just want to make sure -- I guess I'm making a data point here since I'm not just a qualitative researcher. You said that the median length of stay hasn't changed in a decade? It was 17 in 2000 and 17 now? I think it would be great to add that row to that table.

You now have some good text pointing out that that's also a problem. We are focused on this sort of burgeoning of the average length of stay, but I just think we want to -- in the long run, we are as concerned about

that other issue. So I just wanted to highlight that point and urge you to broaden that table.

DR. NAYLOR: So thanks, Kim, for a great report. I don't know if you've done this before, but the 42 percent of Medicare beneficiaries that have used hospice, have we ever compared their total costs to the 58 percent who have not, considering inpatient costs, et cetera? I mean, I know about the caps. So I'm just wondering.

MS. NEUMAN: We have not done our own calculation of the costs of hospice, people who use hospice at the end of life versus people who don't. There is research that has done that kind of thing.

DR. NAYLOR: And could you summarize?

MS. NEUMAN: Sure. I think if you look at the last year of life and compare people who used hospice and not, I don't think you see a cost difference. I think that if you start to look at patients with different kinds of characteristics, patients with different diseases, different lengths of stay, you can see some savings or some additional cost depending on, you know, how long they were in hospice and what condition they have.

So it's a mix. But if you look at the last year

of life, just in aggregate, there doesn't seem to be a difference.

DR. NAYLOR: So given that this is -- I mean, I guess, I think this is a natural opportunity again, especially since this is a benefit intended to be even shorter term than that, it would be great to kind of get a sense of what those comparisons might look like given the differences in terms of total cost for hospice versus inpatient.

So this is probably, as a new Commissioner, the notion of excluding the bereavement costs, I understand that that has to do with, I guess, beneficiary-directed costs. But I'm wondering -- it looked like it could have a fairly significant impact on margins, about 1.5 percent I think you estimated, and given how important bereavement is in the long haul, because we know that people that care for people who die have higher chronic conditions and greater use of acute care resources, and the nature of this benefit, can you just give me some of the background for why excluding in this benefit?

MS. NEUMAN: So the statute says that hospices are required to provide bereavement to the families of deceased

Medicare beneficiaries. But the statute also says that the Medicare payment rate for hospice shall not include payment for the bereavement counseling. So because of the way the statute is written, it's considered a non-reimbursable cost and our approach on estimating margins is only to look at reimbursable costs in our margin calculation.

That said, we're reporting it out for you so that you have that information. I think if you want to go back and sort of wonder the philosophical reason why the statute did what it did, I think it partly relates to the idea that once the beneficiary has passed away, then there's uneasiness about continued Medicare spending once the person who sort of qualified for the benefit is no longer with us. That's kind of, I think, the philosophy behind it. But it's a difficult issue.

MR. HACKBARTH: So it's a service rendered to a non-Medicare beneficiary. Having said that, when I think about what the appropriate update is, I do the calculation that you suggested. I think Kim's margin here and then do a calculation in my head, what would the bottom line be if, in fact, the bereavement costs were included.

DR. MARK MILLER: And I think that's some of what

-- we discussed this in December, and I think that's some of what drives you to go to 1 percent here.

DR. NAYLOR: I wanted to clarify that that was part of our thinking. I knew it was from December. I wanted to make sure it carried through.

DR. MARK MILLER: It is. Can I just say one other thing about your first question? Jim and Kim know this much better than I do, so I just want to say this carefully. We can also excavate this, because this is from the past and we can give it to you specifically just to help bring you up to speed, because they went through this literature carefully because there is this sort of standing thing, a hospice saves money.

But it's more complex than that. And the way I think about it, just to -- well, for me, a relatively simpler way to think about it is, the line of whether it saves or costs money is directly related to how early in the process the person comes in. The earlier they come in, the more likely it doesn't because remember what Medicare does, is it just pays on a daily basis.

So it's sort of how soon -- and to the extent that we're concerned at the highest lengths of stay are growing

the fastest, that calculus is potentially kind of coming apart, that it's not going to be a benefit that on net saves money. So it's very much -- costs less than conventional care. It's very much a function of, as Kim said, the kind of patient that comes in and how long and how far in advance of the date of death that they come into the benefit. I'm looking at you. I'm pretty sure I didn't help.

DR. NAYLOR: It all gets back to the same conversation we've been having. We target the right people.

DR. MARK MILLER: Well, and the right time for them to answer --

DR. NAYLOR: And the right time, et cetera.

DR. MARK MILLER: -- the benefit.

DR. NAYLOR: Yeah, exactly. And I think the Affordable Care Act's focus on getting the right quality measures for assessing how well we're doing is also -- it's so complex, but yeah.

MR. HACKBARTH: So as I recall, Kim, one of the more widely quoted studies on this issue is done at Duke, I think. When was that study done? And more importantly, what years' data were they using to try to make this comparison? Do you remember?

MS. NEUMAN: No, I don't recall that study. It's several years old now. I would need to go back and look. They found the most -- some of the most favorable results in terms of cost savings of the literature that's out there.

MR. HACKBARTH: And so, I wonder whether, given the trends in the patterns of hospice utilization, whether it makes sense to do an analysis such as Mary is describing with more up-to-date data that reflect current patterns of use of hospice as opposed to what may have existed five or six, or whatever number of years ago.

DR. MARK MILLER: Jim, did you go through that?

DR. MATHEWS: We did early on, and in addition to the length of stay, one of the other significant drivers with respect to whether or not use of hospice makes a difference in terms of Medicare spending for decedents, is whether or not the terminal disease is likely to, under typical circumstances, trigger the use of expensive Part A services.

So, for example, to take the LTCH example, if a person with a terminal condition who might have gone to an LTCH instead elects hospice, that situation is more likely to result in lower Medicare spending than it would be for a

patient with a terminal condition that typically does not utilize a lot of Part A care.

So, for example, debility or adult failure to thrive, which are also conditions that typically have longer lengths of stay. So that's another driver. And again, there is fairly extensive literature on this. In addition to the Duke study, there was a RAND study in 2004 that is generally regarded as methodologically one of the best pieces. I think we can probably dig up our literature review for you and get it to you.

DR. CHERNEW: I just feel obliged to make this point, which I should say, I'm as fiscally conservative as the next guy, at least in Massachusetts, but probably other places as well. It's just, I feel obliged to say, saving money is not the bar and I challenge us to go through the fee schedule and find the specialties which save money.

So while understanding the fiscal consequences of what we do, per this discussion, I think is crucial. I think it leads us to hold services like hospice to a bar that even a fiscally conservative person should say is not what the bar should be.

MR. HACKBARTH: And I think that's a really good

point, Mike. On the other hand, people shouldn't be allowed to make the argument in favor of more payment for such-and-such on data that isn't up to date.

DR. CHERNEW: And we should be concerned about the cost relative to the quality. I agree 100 percent.

MR. HACKBARTH: Yeah. We're in 100 percent agreement. So were you finished, Mary? Tom? Mitra?

MS. BEHROOZI: Thanks, Kim, for looking into the issue of volunteers. When you say that you don't count in the margin calculation the non-reimbursable volunteer costs, I think we talked last time about the fact that that would be like the cost of recruiting volunteers or that kind of thing, because by definition volunteers don't cost any money. Right? I just wanted to make sure that that was clear, right? Is that correct?

MS. NEUMAN: Right. The volunteer costs reported on the cost report would be things like recruitment. There's a volunteer coordinator and that person recruits and trains the volunteers. There are also some -- they pay mileage reimbursement to their volunteers and things of that sort. It turns out, in doing more research on this, there's a little bit in the paper, that some of these costs, the

recruitment and the training apparently, some of them are getting allocated to reimbursable costs. So it's only the stuff that's going in the non-reimbursable that we are [off microphone].

MS. BEHROOZI: So then you report in the paper that per the survey, the hospice survey, 5.6 percent of clinical staff hours in 2009 were provided by volunteers. So have you done any analysis of what impact that would have on the bottom line, if hospices had to pay for those services, and it's actually a two-part question.

The second is, can you tell from the survey, can you get a distribution of who is using those services? One of the bigger concerns, of course, is for-profit versus not-for-profit. Is it high margin versus low margin? That kind of thing.

MS. NEUMAN: So the data I was citing in the papers from the NHPCO survey, and so I'm citing data that they've reported out in an aggregate level. I don't know the extent to which there's more detailed information on sort of the hospice characteristic, but I can look into that.

I have not done a calculation of what the impact

would be if they paid for these services rather than having volunteers do it. It's something I will think about how to do. It's going to be complicated in the sense that when volunteers provide patient care, for example, there are physicians and nurses and folks who are volunteers, but then there's also just folks, lay people, who want to help and they may be helping with shopping or sitting with the patient while the family member goes out to do something. That kind of estimating what would happen for that, in terms of their cost, is difficult. So it's something that we can think about, but it's going to be hard to get a very strong number here.

MR. BUTLER: So I think I'm right in that hospice, if you're in an MA plan, the hospice benefit sits outside of the MA plan and we keep referencing MA plans and what do they do. I'm just kind of curious in this respect. I would think MA plans would be encouraged to, incentivized to make ample use of hospice for their members. Is there any data around that?

MS. NEUMAN: So we have in one of the early tables in the paper, we have the rate of hospice use for Medicare Advantage decedents versus fee-for-service, and it is

higher. I think the number is 46 percent. Let me just check here. Yeah, 46 percent of MA decedents in 2009 used hospice compared with 41 percent in fee-for-service. So we do see a little bit higher hospice use.

I've looked also at length of stay and things like that. It doesn't look that different on length of stay. That's about it right now for the data I have on MA versus fee-for-service.

MR. HACKBARTH: Okay. Round two comments. Karen, Scott, Bruce, Kate, Nancy.

DR. KANE: I think I'm happy to support the one percent, partly because of the issues we discussed, although it's the most generous that we've given and we've given it to the acute hospitals whose overall margin was negative and we're giving it to physicians even though we don't know their margins. But I think the lack of quality information makes you a little concerned as to -- lack of quality information and proper criteria for use does make you very concerned about this, and the fact that this is mostly for-profit business and what are we doing here, attracting more use and better returns without really quite knowing when people should use it and whether the quality is good or not.

So I'm a little concerned --

MR. HACKBARTH: Yes.

DR. KANE: -- and I think we should keep trying to work on how to get better data.

I think in the future, which I won't be a part of -- it's kind of nice to have it be a last year so you can make all kinds of comments that other people have to worry about -- it would be great to start thinking about how you can get facility criteria and/or patient criteria that really make people have to sign off on, what's the right -- or a shared decision making model or something that focuses on end-of-life care, that really thinks about the behavioral part of end-of-life care and maybe it's required that people go through the counseling that's needed to make proper end-of-life care decisions for their family, not economically driven at all but really for quality of life.

And I think there's a special need to do something around mentally impaired, and I think we were talking the other day, maybe there's something in between hospice and LTCH or SNF that's really respite type of care, that I don't know that Medicare pays for yet, but maybe we have a whole group of people who have mental impairment, dementia -- I

don't know what failure to thrive is, but maybe that's related, as well -- maybe there needs to be really a lot more thought to how does society care for these people most effectively and keep them in the community as long as possible. It might be a respite problem for the caregiver more than it is -- they don't need a lot of acute medical attention.

So I just think this whole post-acute, especially as you get closer to the end of life, needs a lot more attention into the best way to direct people. So anyway, I will support the one percent, but I would be more comfortable with a half-a-percent because of the problems, not because they're undeserving.

MR. HACKBARTH: Yes. A quick reaction on, actually, both of your points. On the first one, comparing what we're giving for different provider groups based on margins, I would just add one qualification to that, which is, yes, the bottom line for hospitals is one percent, but what we've said is that but for DCI, the DCI adjustment, we would have given a two-and-a-half percent increase. So if we just look based on financial performance and make that comparison across sectors, we would have given substantially

more to hospitals. But we do have this DCI issue that we need to deal with.

On the second issue, I think in the last couple discussions, you've made some really important points about how patients get to the proper services. One of the challenging aspects of fee-for-service Medicare is that you've got two types of tools that you can use to try to deal with that. You can try to adjust payment rates and you can write regulations. And unfortunately, those are often relatively crude tools to deal with very subtle issues and differences among patients. Ultimately, that's the argument for more organized delivery systems that can better manage the patient's needs and have responsibility for the full spectrum of services and care under the rubric of a single payment. There, you can have clinicians that are intimately familiar with the patient, with the proper incentives, directing them to the needed services given their -- not just their condition, but also their personal tastes, preferences, and all that. There's only so far we can go in fee-for-service using adjustments in payment rates and writing rules to get people to the right place. There are inherent limits.

DR. KANE: I agree, and I do look forward to that future, which is hopefully more likely than some of our other futures we've been -- I mean, I look forward to that happening. But I think to foster it along the way, and given that we're still mostly in this other world, it would be helpful to have these criteria, some sort of criteria that people really try to think about now for when people should be directed to what care --

MR. HACKBARTH: I would put in a plug for payment reform, since --

DR. KANE: I'm all for it.

MR. HACKBARTH: -- as our other payment lever.

DR. BERENSON: Can I make a comment on that?

MR. HACKBARTH: Yes.

DR. BERENSON: When you were talking about something in between LTCHs and hospice and describing something for cognitively impaired, you -- it sounds right, but it sounds like it's awfully close to long-term care and that's sort of where we draw a line. So it is a problem as to when we get into that area, what we actually can do within the sort of structure of the program at this point, I would think.

DR. KANE: I get the sense that there's quite a few people with mental impairments who are getting into either hospice or SNF under Medicare, because we've talked a lot about them, and it is a diagnosis that seems to show up a lot, and if you're in a hospice for three years with dementia, I kind of think there might be a better alternative, and that's all. I mean, I'm really --

DR. BERENSON: I think that's right, but I don't think we --

DR. KANE: I agree with you.

DR. BERENSON: I don't think people should be in hospice for three years with dementia. I think that's the problem that we're trying to address right now.

DR. KANE: I hear you.

MR. HACKBARTH: Round two comments. George?

MR. GEORGE MILLER: Yes. I think I can support the recommendation, also. I somewhat tend to agree with Nancy about the amount, and mine is for a different reason, and that is because, quite frankly, the growth in for-profit hospice over the time. I'll give an anecdotal story. At least at two of my hospitals, we support the local hospice, and in one case, our nurses volunteered as part of the

process. So we thought that hospice was meaningful. It was part of our corporate responsibility to help support the local hospice because of its mission and enhance the community benefit.

But I am very concerned about the growth in for-profit hospice, and that seems to be the majority of the growth over the last ten years. So with that said and the lack of quality, I struggle with the need for a one percent increase without having that vital information. So I'll sit here and contemplate the way I will vote before -- or by the time we make the decision. I would support Nancy and maybe a half-percent would be more in line because of the lack of information and growth of for-profit hospices.

DR. NAYLOR: So I strongly support the recommendation and I'm heartened by the fact that CMS will be publishing quality indicators in the same year that this payment update is going into place so we will have kind of a concurrent opportunity to assess quality as we go forward.

DR. DEAN: Yes. I think I can support the recommendation. A couple of thoughts. Just to comment on the discussion we had in the first round, it just seems to me -- it bothers me that we put in requirements and then we

say we're not going to pay for them, you know, the bereavement costs. I mean, the government is famous for that and that money has to come from somewhere, which means it probably comes from either private pay or other insurance or whatever. It happens a lot. I'm much more familiar with nursing home care and it happens a lot there. And so it's just troubling. I think it's certainly a legitimate service. I think the requirement that it be there is very appropriate. But that you require but not support it is illogical, in my view.

I'd like to comment on something that was in the paper that I think really deserves more consideration, and that's the idea that perhaps people should be eligible for hospice without completely rejecting curative care, because in -- and I don't have a lot of experience with hospice. It's not widely used in our area. But in the discussions that I've had, I think that's something that really frightens people and I don't think they understand how a hospice service can really take the place of acute care.

From what I understand from the literature that exists in this area, when that requirement of completely rejecting curative care was relaxed, that, in fact, people

really didn't tend to use curative care, but having it available provided a little bit of sense of security and probably would allow people to choose this service, the hospice service, at a much more appropriate time, which would mean earlier in the phase of -- earlier in the course of their illness, because we know that we're worried about long stays, but in my experience, the people that sign up for hospice, usually by the time they get to the point where they really finally have decided, yes, curative care is not going to work, they've got a few days left to live and hospice intervention really doesn't provide much benefit. So I think we really need to give some serious thought.

I think an analogy in some of the insurance literature, when you are asking people, would they agree to an insurance policy that had a closed panel of physicians versus free choice of physicians, everybody would say, we want the choice. In fact, when you gave them the choice, they frequently didn't use it. But it was the option of having it available was really a pretty important force in their decision about which sort of structure they were going to choose.

I think in trying to make better use of the

potential benefits that hospice has, this is an issue that I think deserves some serious consideration and hopefully would get away from these really short stays where, you know, hospice doesn't do much good.

MR. HACKBARTH: This is a really important issue, Tom, and thanks for raising it. In a way, it echoes back to Bob's comment in the first round. There are issues at both ends of the continuum, stays that are too long and also opportunities lost with stays that are too short, when the admission is too late in the process.

DR. DEAN: Yes.

MR. HACKBARTH: I think it was maybe six months ago, Atul Gawande wrote his very compelling piece in The New Yorker about end-of-life issues and this was one that Atul focused on.

DR. DEAN: Yes.

MR. HACKBARTH: My recollection of that is that there has been some research -- and Kim and Jim, I'm going to need your help there -- there has been some research. Aetna, as I recall, did a demonstration on this and concluded that, in fact, it did not cost more money in order to waive the requirement. And then, also, PPACA, as I

recall, requires a test of this issue, is that correct?

MS. NEUMAN: Yes. There's going to be a three-year demonstration in 15 sites to waive the curative care requirement within the Medicare population and see what the effects are. So my understanding is that that's -- the sort of plan for that is still being worked out. It hasn't been released yet. But that's in the law.

And then, as you said, there's the Aetna study, and the thing that's a little bit different about that is it's a commercially insured population that's younger with a lot more cancer and so it will be interesting to see in a different kind of population what happens with a similar approach.

DR. MARK MILLER: [Off microphone.] The other difference -- I'm trying to remember when we talked about this last time -- was the Aetna study conducted in the context of a managed care plan?

MS. NEUMAN: Yes.

DR. MARK MILLER: And that's the other variable to keep in mind. There's not just the differences in the populations. And this comes up -- Mike has made this point, Scott has made this point, many of you have made this point

of when you take a good idea and then put it in a fee-for-service kind of open-ended unmanaged environment, will you get the same result that you got in that environment, and that's -- I think that's another thing that the demonstration may bring out.

DR. DEAN: One other issue, and it follows up on some of the things that Nancy was saying, I think that we need to also, just to repeat, I guess, what Nancy say, try to be sure that we're encouraging people to get to the programs that have the services that really serve their needs. And it does bother me that, for instance, we have this large component of people with dementia going into hospice because hospice, as I understand it and my experience, has some -- obviously, it's a terribly important service, it's a terribly valuable service, but it has certain skills that I'm not sure are relevant or fit real well with the needs of people with Alzheimer's disease, for instance.

Hospice are really experts at dealing with pain and fear and those kind of situations. Those are not really the needs that people with Alzheimer's tend to have. Their big needs in the Alzheimer's situation are usually with the

caregivers rather than with the patients themselves, and caregivers need huge amounts of support, but that really isn't the core of hospice services, at least as I understand it.

So I think -- I don't know exactly how you do this sorting, but I think it deserves some thought.

MS. BEHROOZI: A couple of different points. I think that where Nancy is going, talking about respite care or long-term care, whatever you want to call it, I think we can't avoid it. I recognize that the program says there is no long-term care benefit, but I think we talked about it in executive session maybe last time or the time before, and I don't see Evan here, but there were a couple of Federal court decisions overturning denials of home care payments where the justification for the home care was to prevent deterioration and thereby prevent hospitalization or whatever.

So it's encroaching, kind of. And Scott talks about the kinds of services that he provides to a Medicare population to keep them from becoming more acute. So, you know, it's kind of seeping under the door or whatever, so I think we do have to pursue -- whatever, make

recommendations. Think about making recommendations that really are transformative of the program as opposed to incremental around the edges.

I just wanted to -- when you talked, Glenn, about getting people to the right place, you talked about two ways of doing that, payment rates and regulation, but yesterday we spent a whole lot of time on the third way, which is cost sharing to the beneficiaries, right, and driving their behavior. And the fact that there is no copayment here -- I am not an advocate for copayments, you know that. And I'm not just trying to be a lawyer and be consistent. But rather, I think this ties into the cost savings issue, I think, as I understand it. And this just might be a small slice of it, but that was one of the reasons, I understood, for there not being a copayment associated with hospice because I thought the idea was that this would be a high-value service, not only to the beneficiaries who wouldn't have otherwise have had this service, but that there would be a net savings, right.

So when we're talking about the overall benefit design, if you started from scratch, what would you do, I think we have to, yes, think about that.

And then on the rationale for the one percent. I'm glad that Nancy raised it, because I was actually looking at our handy-dandy little chart here, and just from the discussion before, I think -- again, not just to be consistent, but I think we need to make it clear why we're not doing here what we did with LTCHs, for example, where the margins are similar. Last year, or 2009 was 5.7 for LTCHs, 5.1 for hospice. Two-thousand-and-eleven projected 4.8 in LTCHs, 4.2 in hospice. The variation is broad in both areas, a little more in hospice actually than in LTCHs. You've had the doubling of freestanding hospices in the last ten years.

Paying for the bereavement that they're not reimbursed for, I'm not quite as sympathetic, I think, as some of my colleagues are. The paper made clear that the 1.5 percent is possibly an overstatement and it varies between for-profit -- I'm sorry, yes, with not-for-profit providers having about two percent bereavement costs and for-profit providers having somewhat more than half -- I mean, a little more than half that. One-point-one percent of their total costs are bereavement costs. So I think they're probably able to offset some of that with their

volunteers that they're not paying.

So I don't know that that justifies our going all the way from zero to one. If there are other rationales, I think we need to be clear about them. Otherwise, I think with Nancy and George, I would opt for less than one, given the comparisons to the other areas.

MR. BUTLER: As we try to convert all this qualitative research to quantitative and particularly across these post-acute care sectors, I'm almost back on the qualitative side in the sense that we're getting into very sensitive issues. I would really enjoy a panel of, say, a leading MA plan, a pilot ACO, a post-acute care bundling company, somebody that we could hear about how they philosophically are approaching this in their own organization to give a sense of what the real opportunity is besides just kind of bundling this stuff together and the trade-offs and the readiness for it, because we have this philosophy, we want to hand off responsibility for the, particularly the post-acute care continuum, and I really would kind of like to understand better how some are doing this, and not maybe ones that are just shooting the lights out but ones that are kind of struggling with this. It

would help me understand how well we're really culturally going to be able to implement some of these trade-offs which quantitatively may look obvious at some point to us, but they're more difficult to implement than you may think.

DR. CHERNEW: Thanks. I am supportive of the recommendation, but one nice thing about a siloed system is you get to make the same comment again and again and again -

[Laughter.]

DR. CHERNEW: So this is another example, as people have said, about going for the type of person. So in my mind, it's not about hospice. It's about cancer patients. And it's not about hospice, it's about patients with Alzheimer's or whatever it happens to be.

One of the subgroups that I think is particularly important that hasn't really been discussed much is patients in nursing homes that then need hospice, where there are some separate issues. We wrote an issue on this, and just for Tom's comments, we actually in that paper advocated removing the requirement for relinquishing access to curative care for folks in nursing homes and a series of other things related to that. And I do think there's a lot that could be done to think about criteria for getting a set

of services that aren't necessarily hospice per se, but a set of services people need as they get closer to the end of their life, whether it be six months or whatever it is. There's a whole series of things that one might think about, and again, it very much depends on the diseases.

The only last thing I would say -- and again, that's not for this, but I think as we go through and think about this, I think Peter's suggestion was very wise in that regard.

The only other thing I would say is I have very mixed feelings about George's comment about for-profits entering. On one hand, I do think it's something you might worry, not because I am against for-profits. As an economist, you know I love for-profits. But you worry that there are a lot of folks coming in, and if we thought they were coming in and doing really good things in underserved areas because they're very nimble, that would be great and I think that's the beauty of having for-profits being able to do that, and it certainly does soothe me to think that we aren't too low in what's going on.

On the other hand, because hospice is such a difficult service to measure quality and costs, and I'm

written on fiscal Armageddon and so I worry about all of that other stuff, you worry that there aren't some opportunities for people who aren't doing a very good job and how to deal with that, which is one reason why I supported the copay before and you could probably convince me to support copays here. Mitra will later.

But in any case, that's really what the challenge is, and it's the challenge in being able to measure quality, not quality of the hospice per se, which is going to have a lot of heterogeneity, but quality of the process for the beneficiaries and what organizations can fit in well and how we can set up in our paper on hospice. One of the big things was who is ultimately responsible, not for the hospice care or not for the nursing home care, but for the continuum of care, which we took a lot of flack for, actually. But finding that person or that organization that's responsible over the spectrum of care is just really important, and I think we have to think about how we can use bundling or whatever and quality measurement to encourage that.

MR. HACKBARTH: So I want to go back to Mitra, who raised several really important points, one about the copay.

This is an issue that Bob has also raised before, that there are some similarities between the issues we're wrestling with in home health and hospice and we ought to be thinking about potentially a copay for hospice. And so I think that's definitely something that ought to be discussed as we move into broader discussions of a benefit package next month.

On the second issue that Mitra raised, comparing our recommendation for LTCHs and hospice, here's my thinking, and it again comes with a caveat that the nature of this enterprise is there aren't right answers, but I just wanted to lay out my thinking and why I thought a higher number was appropriate for hospice than for LTCHs. There are two elements to it.

One is if you look at the history of margins for the two sectors, you know, going back seven, eight years, hospice have been pretty consistently in the four or five percent range, say four-and-a-half to six, in that range. LTCHs have had a history where three or four years ago, they were substantially higher, up at the 11.9, ten percent -- 11.9, 9.7 percent area.

And now I'm going to relate it to something that

Mike just said. In LTCH, we have a service about which we have particular uncertainty about where it fits in the appropriate care delivery system, substantial profits, a substantial rush in of for-profit activity. And frankly, one of my thoughts about LTCHs has been we need to hold down the margins to deter lots of new entry for a service that we're not even sure where it fits in a high-performing cost-effective delivery system. Now, in addition to that, in fairness, Congress has taken other kinds of steps, including ultimately the moratorium in PPACA. But because of the history of higher margins and because of the uncertainty about the role of LTCHs in the system, frankly, I have tended there on the low side, not just this year, but in past years with regard to LTCHs. Some of the same issues may exist with hospice, but in my own personal assessment, I didn't think to the same degree.

So that was my thinking. Again, there is not a right or a wrong on this, but I just wanted to respond specifically.

Mitra, then Nancy.

MS. BEHROOZI: I just want to respond on the first point and make clear that I'm not advocating that we impose

a copayment in hospice. When it comes to discussing copayments, I will make the same kinds of arguments, I hope a little more coherently and less passionately, about how -- the factors that you should take into consideration in setting a copayment. So I just wanted to make that clear.

DR. KANE: The profit differential between hospice and LTCH, certainly, you know, LTCH is a little higher, but there's also higher capital requirements and that is how you fund those, ultimately. So, I mean, I just don't think that's totally enough. But I agree that the uncertainty of the value of LTCH is much greater than the uncertainty -- I mean, hospice clearly has value and fits into the system, whereas LTCH, we're just kind of wondering what it really does that a good SNF can't do. But I think if you're going to start talking about higher and lower profits without taking into account the capital requirements, it gets kind of meaningless.

DR. NAYLOR: I just wanted to, also, there's been some conversation about differentiating hospice from long-term care. We've been working with Alzheimer's patients in hospice. They're entirely different patients than people receiving long-term services. I mean, Alzheimer's

represents a coexisting problem in someone who has heart failure, diabetes, and is at end of life. So I think we need to really -- I mean, it's certainly a challenge to know when people are end of life because of the complication of cognitive impairment, but I really think we need to separate our understanding about long-term services versus hospice services for people who happen to have major cognitive impairment.

MR. HACKBARTH: Okay. Just a real short one. We're about a half-hour behind. Karen, go ahead.

DR. BORMAN: Just in terms of as we think about synergies after we get past the updates, the discussion here about criteria and so forth seems to me to marry up to the whole shared decision making process. This ought to be a fertile field for that.

The second thing would be that comparative value across the various post-acute settings, again, I think should be on our list of things to encourage, that the Comparative Effectiveness Center begin to look for what evidence is out there as they begin their work.

MR. HACKBARTH: Okay. Would you put up the draft recommendation. Okay. Time to vote. All in favor, please

raise your hand.

Opposed?

Abstentions?

Okay. Thank you very much.

And our concluding session is on Medicare Advantage. This does not involve a vote on an update recommendation, but we do include a chapter on Medicare Advantage in our March report each year.

Scott and Carlos, you can begin whenever you're ready.

DR. HARRISON: Okay. Today Carlos will present the quality-of-care sections from the draft MA chapter that you have, but first I want to briefly remind you about the enrollment and payment sections that I presented in November and answer a question also from November. Then I will stay at the table to answer any questions you may have when you discuss the chapter as a whole.

First, the question. Bob, you wanted to know the relative risk in plans versus fee-for-service. For 2011, the plans project an average of 2 percent higher risk than fee-for-service, and that is up from 2009 when they projected the average risk would be the same as fee-for-

service.

DR. BERENSON: Just quickly, that's before the adjustment for the coding, intensity.

DR. HARRISON: Correct. Okay. Now to summarize from November, over the past year enrollment in MA plans grew by about 5 percent, to the current level of 11.4 million beneficiaries. Currently, about 24 percent of Medicare beneficiaries are enrolled in MA plans. Enrollment did begin to shift out of private fee-for-service plans and into PPOs and HMOs as plans responded to network requirements that were mandated in 2008 legislation.

For 2011, plans are available to almost all beneficiaries, and I say "almost" because 0.4 percent of beneficiaries do not have a plan available.

The average number of choices per county declined from 21 to 12 over the past year, and the decline was due to the decline in private fee-for-service choices. The average of eight coordinated plan choices per county remained the same.

Also, we estimate that, on average, Medicare will pay about 10 percent more to cover a beneficiary in an MA plan than it would have paid to cover the same beneficiary

in fee-for-service Medicare.

And, finally, when we examined the PPACA benchmark changes that will be phased in by 2017, we found anomalies that would cause benchmarks in some lower fee-for-service spending areas to exceed those in some higher fee-for-service spending areas.

And now, as promised, Carlos will present the quality sections.

MR. ZARABOZO: Today I will provider an update on recent trends in the quality indicators for Medicare Advantage plans, and I will also discuss changes in the law that introduced a quality bonus payment system for MA. At the outset, I would like to thank Kelly Miller for her careful work on the CAHPS data that I will talk about, and thanks also to Carol Frost for help with the population distribution data.

Before we examine MA plan performance on quality indicators for the most recent time period, some background is helpful to put our discussion in context. Last year, the Commission issued a congressionally mandated report that dealt with two issues: how to better evaluate quality in the Medicare Advantage program, and how to compare quality

in MA plans to the quality of care in fee-for-service Medicare. The report had a number of recommendations, such as the need to develop more outcomes-oriented measures appropriate for the Medicare population and the need to collect more data from MA plans. In addition, the report discussed ways to use available data, and new data, to compute performance levels in MA and fee-for-service Medicare. The report also emphasized the need to ensure strict comparability when comparing one plan to another or when comparing MA to fee-for-service, for example, by making comparisons at the appropriate geographic level.

Something that is also of relevance to today's discussion is that the Commission has recommended that there be a pay-for-performance system in Medicare Advantage to provide additional payments to plans with demonstrated higher quality.

With that background, we can report on the current status of some of the recommendations. CMS recently issued a proposed rule in the Federal Register in which the agency stated its intention to proceed in the direction suggested by the Commission's recommendations, for example, by emphasizing outcome measures and developing additional

measures for older Medicare beneficiaries.

In terms of concrete changes that have occurred or are in the works, CMS and the National Committee for Quality Assurance are working on developing new quality measures for the MA population. In addition, CMS is proceeding with its plan to collect detailed encounter data from MA plans, which can be a rich source of data for comparing MA to fee-for-service. The encounter data collection is scheduled to begin in 2012.

In another change, CMS now allows preferred provider organizations, or PPOs, to report certain quality performance measures in the same way as HMOs, which can put such plans on a more equal footing when evaluating quality.

And, finally, in terms of new developments, recent legislation -- PPACA - introduced a quality bonus payment system for MA beginning in 2012.

Many of the recommendations that the Commission made in the mandated report to the Congress last year were expected to take several years to implement. Thus, there are still issues with how to go about examining quality in MA and how we can compare quality in MA to quality in the fee-for-service sector. As we will discuss in further

detail, we see a lot of variation in plan performance as measured by the current quality measurement systems, but the data suggest that in some cases these differences do not necessarily represent differences in quality across plans. Instead, the differences may reflect specific circumstances or characteristics of individual plans, including, for example, the geographic area in which a plan operates, or the composition of enrollment of the plan.

We will also discuss the decision that CMS made to use a program-wide demonstration to implement the quality bonus program rather than the approach outlined in the PPACA legislation. We will talk about this in detail after presenting our most recent findings on the state of quality in MA.

Before moving on to look at the actual results of MA quality indicators for the current reporting cycle, I will remind you of the three sources of quality indicators that we use to judge the performance of MA plans, which are shown in this table.

HEDIS is a set of process measures and intermediate outcome measures that plans report.

The Health Outcomes Survey, or HOS, is a survey of

Medicare beneficiaries asking about their health status and use of services, and it is used to compute measures of improved or declining mental and physical health.

The third system is CAHPS, a survey of beneficiary perceptions of the quality of care they receive, ease of access to care, and health plan responsiveness. CAHPS is also the source of information on vaccination rates for beneficiaries in MA and fee-for-service. Because CAHPS surveys both types of beneficiaries, fee-for-service Medicare beneficiaries and MA enrollees, CAHPS can be used to compare MA to fee-for-service.

Beginning with the first system I mentioned, HEDIS, we see what we have typically seen over the last several years for HMO performance. There has been some improvement in HEDIS results, with nine measures out of 46 effectiveness-of-care measures showing statistically significant improvement over the preceding year, which is slightly better than the performance in the last cycle.

Plan performance is highly variable for many of the measures; in particular, we see in the intermediate outcome measures that the top performing plans have rates that can be nearly five times better than the rates among

plans in the lowest decile of performance. These intermediate outcome measures are perhaps the most important measures in HEDIS. There are seven such measures out of the 46 effectiveness-of-care measures; they include measures of control of blood sugar, cholesterol levels, and blood pressure.

The current HEDIS results also show what we have seen in the past, which is that newer HMO plans -- those that entered the program in 2005 or later -- tend to perform more poorly on HEDIS measures than more established HMO plans.

We also see that local PPO plans have results that are similar to HMO plans on measures that do not involve the review of medical records. Although PPOs can now use medical record review, it appears from the data that the PPO results are still often claims-based results without a medical record review component.

There are about 400 HMOs or local PPOs reporting HEDIS results. Regional plans also report HEDIS results, but these are large plans covering wide geographic areas under one contract. HEDIS reporting is at the contract level, so the most recent HEDIS data set includes 13

regional PPO entities reporting. To the extent that a comparison is possible, regional plans appear to perform more poorly than other plan types. Having said that, we should also point out that there may be a reason for the differences we see with regional PPOs, and that is that these plans tend to attract more beneficiaries entitled to Medicare on the basis of disability. Eighteen percent of regional plan enrollees are under 65, compared to the 11 or 12 percent in each of the other plan types. This population difference could explain some of the performance differences for the regional plans. We mention this in part to reiterate a point that we make in the mailing material, which, again, is that sometimes what appear to be differences in quality of care across plans may be a matter of other kinds of differences, such as the example we gave in the mailing material of a sophisticated medical record system possibly explaining much better scores on one specific HEDIS measure for a particular group of plans.

Turning now to the Health Outcomes Survey, the vast majority of plans have results showing that there are few outlier plans in terms of whether their members had improved or declining health over a two-year period compared

to expected results and compared to the MA average. This is similar to results in each of the past several reporting periods. This year, the only outliers were in mental health, with eight plans showing better results and 13 plans showing worse results.

Turning to CAHPS, in your mailing material we included a comparison of vaccination rates and access to care measures between MA and fee-for-service, but we noted how one geographic adjustment that we made altered the results of the MA to fee-for-service sector comparison. To address this issue, we have adjusted the CAHPS results to attempt to match geographic areas between the two sectors. We use state-level data to arrive at a national rate for fee-for-service to compare to the national MA rate. The fee-for-service rates are adjusted by the state distribution of MA enrollment across the country. In that way, the fee-for-service rate represents the fee-for-service rate for the areas in which MA plans enroll their members.

After this adjustment, what we find is that vaccination rates are similar in MA and fee-for-service, with pneumonia vaccination rates being slightly better in MA. We also see that measures of ease of getting care and

access to a specialist are similar, with fee-for-service showing slightly higher rates of beneficiaries reporting that they usually or always got a specialist appointment, as well as care for an illness or for routine care as soon as the person wanted it.

This is the first time we have examined fee-for-service to MA differences using CAHPS, and we are still working with the data. We need to be very cautious about making statements about the performance of one sector versus the other based on the overall CAHPS results. When we look more closely at the data, we see that there is wide variability across geographic areas and across population types. While we have used one method to attempt to address the issue of geography, there are other factors to consider, such as variation by population types. One example that we noted in the mailing material, for example, is that employer-sponsored MA enrollees have higher vaccination rates than other types of MA enrollees; therefore, plans with a higher concentration of such enrollees would have a higher plan-wide rate.

The upshot of this is that while CAHPS can be used to compare MA and fee-for-service, factors such as geography

make a difference and need to be considered. As I mentioned, in the congressionally mandated report we recommended that comparisons between MA and fee-for-service be made on matched geographic areas. Currently, CMS posts CAHPS results for fee-for-service at the Plan Finder web site at Medicare.gov. So, for example, a beneficiary choosing among different MA plans can see area-level fee-for-service vaccination rates and MA contract-level rates. For most states, state-level fee-for-service CAHPS results are being reported, but there is often a mismatch with MA results because beneficiaries are comparing the fee-for-service results to MA results that could for multi-state plans, such as regional PPOs, or could for an HMO or local PPO that is operating in a very small area within the state.

We will now examine how CMS uses the data collected through the three sources of quality performance measures to rank MA plans. For several years, CMS has been using a 5-star rating system to provide relative rankings of plans. HEDIS, HOS, and CAHPS are major sources of information for determining a plan's star ratings.

There are 51 individual measures that make up the star system. Each measure is awarded 1 to 5 stars. All of

the 51 measures are averaged to arrive at an overall star rating, with a slight increase possible through an integration factor that recognizes a plan's consistently high performance on the measures.

The combined average of the 51 individual star measures for both Part C and Part D -- that is, the drug component of an MA prescription drug plan -- determines what a plan's overall star rating will be.

Generally, the Commission has viewed quality measures as including clinical quality measures and patient experience measures, as we described in the mandated report to the Congress. In last year's March report to the Congress, we raised a concern about the methodology for determining star ratings. On this table you see that most of the measures used to determine star ratings come from HEDIS, HOS, and CAHPS, the first rows listed. However, for the Part C rating -- that is, the rating of performance under Parts A and B of Medicare -- seven measures are contract performance measures, making up 19 percent of the 36 Part C measures. Looking at the middle column, the Part D measures, which measure the performance of an MA plan's drug plan, we see that two-thirds of the measures are

administrative in nature or contract performance measures. In the last two columns, looking at the combined results, which are the basis of a plan's overall star rating, we see that about one-third of the measures are contract performance measures.

The contract performance measures that we are talking about include three call center measures, which are the amount of time a caller remains on hold, the accuracy of information provided to callers, and the availability of foreign language interpreters and telecommunications devices for the hearing-impaired. Three other Part C contract performance measures deal with appeals and complaints, and another measure is based on corrective action plans that are put in place based on CMS monitoring visits. Disenrollment rates were not included this year because CMS did not have the information available. The 15 Part D measures for MA-PD plans include three CAHPS measures of patient experience and two clinical quality measures, in addition to 10 measures that are contract performance measures.

Until this year, the overall star rating for MA-PD plans was based on their Part C performance, with no Part D component. Because the measures in Part D are predominately

contract performance measures, as we have discussed, the new approach increases the weight of contract performance measures in the overall star rating.

For some plans, the contract performance measures can be an even higher proportion of the plan's star rating. This is because plans can have star ratings even if they are missing measures. Looking at this year's data, we see that there are plans with overall star ratings for which half of the available measures are exclusively contract performance measures.

Now we will talk about why the concerns we have about the star system have taken on much greater importance.

The concerns we have about the star rating system become especially important now that a quality bonus payment system is set to begin in Medicare Advantage. PPACA introduced a bonus payment system beginning in 2012 that called for CMS to use a 5-star system based on data collected under the provision of Medicare law dealing with quality improvement. Under the law, once the bonus system is fully phased in, plans with four or more stars would have their benchmarks increased by 5 percent, and in some counties the benchmark increase would be 10 percent.

The law also changed the rules on rebates. Rebates are the program dollars that plans use to provide extra benefits to their enrollees when a plan bid is below the benchmark. Previously rebates were 75 percent of the bid-to-benchmark difference. That level will be reduced to 70 percent for plans with 4.5 stars or 5 stars, 65 percent for 3.5- and 4-star plans, and 50 percent for plans under 3.5 stars.

In November of last year, CMS announced that it would undertake a program-wide demonstration of a quality bonus payment system that would have a structure very different from the PPACA program. While PPACA awards bonuses to plans with 4 stars or above, the demonstration makes bonuses available to plans with 3 stars and 3.5 stars -- that is, what CMS defines as an average plan, which is one with 3 stars, will receive a quality bonus.

The star system that determines bonuses will be the one that is currently in use, which was originally introduced as a consumer information resource under a different provision of the statute.

Here we illustrate the effect of the demonstration as compared to what would have happened under the PPACA

bonus system. Under the demonstration, about 3.5 times as many enrollees of plans will be in bonus plans. Whereas under the PPACA rules there would have been nearly 3 million enrollees in bonus plans, or about 23 percent of all current enrollees, under the demonstration over 9 million enrollees are in bonus plans, or about 80 percent of enrollees. The inclusion of 3- and 3.5-star plans has different effects by plan type, as shown in the bulleted text on right. While under 30 percent of HMO or local PPO enrollment is in PPACA-eligible bonus plans, introducing the demonstration boosts the proportion of enrollees of such plans in bonus plans to 88 percent in each category. For regional PPOs and private fee-for-service plans, it is only by virtue of the demonstration that half of the enrollees of those plans are in bonus plans. Under PPACA, no regional plans would have qualified for a bonus, and only 1 percent of private fee-for-service enrollment would be in a bonus plan.

Although CMS did not solicit comments on the quality bonus program demonstration, the Commission did provide comments in connection with a recent proposed rule on MA that CMS published in November. In our comments, we expressed several concerns. One was regarding the cost of

the program. It is not a budget-neutral program. It is estimated to cost $1.3 billion more than the PPACA approach to bonus payments over the course of the 3-year demonstration.

We also commented on the design of the program, noting that the incentives are very different from the PPACA design of rewarding only the highest-performing plans. We also reiterated a concern that the Commission has raised twice before, once in connection with a program that increased payments to oncologists, and later in connection with a program-wide demonstration in Part D. The Commission expressed concern over the costs of these programs and the use of statutory authority that was intended as a vehicle for testing innovations.

We look forward to your discussion. In particular, we would like any comments you have on the draft chapter, comments on the issue of relative risk scores between MA and fee-for-service, the unintended inter-county anomalies that Scott mentioned, and the issues that we talked about in quality, including means of improving quality measurement and possibly diminishing the weight given to contract performance measures in the star system.

We also welcome discussion on any other issues you would like to bring up.

Thank you.

MR. HACKBARTH: Thank you. Carlos, in the demonstration of the quality bonus program, what is CMS purporting to test?

MR. ZARABOZO: They think that this will accelerate improvement in plans, as more plans look to get to the higher ranking stars.

MR. HACKBARTH: I'm having trouble.

MR. ZARABOZO: I might have to quote directly from the --

MR. HACKBARTH: Okay. So we're going to start with clarifying questions.

DR. CHERNEW: If I understand correctly -- and I might not -- the star rating system is relative, so it's the top X percent of plans or whatever. So if every plan got better, you wouldn't get necessarily a bonus because your competition is --

MR. ZARABOZO: Right, each of the measures --

DR. CHERNEW: If you stay the same and other plans got better, then you could actually lose your bonus. Is

that the way that it's designed?

MR. ZARABOZO: Yes, each measure -- within measures, you have this relative distribution within measures, so people are moving up, depending on -- different measures are done differently, but if everybody moves up and you stay the same, then, yes, there would be a consequence. You could go down.

DR. CHERNEW: Right. And so everyone can't race to get to the top and then everyone get the bonus because it's all relative. So unless this is Wobegon -- is that Lake --

MR. ZARABOZO: Lake Wobegon, yes.

DR. CHERNEW: Where everyone's above average, but other than that, they can't do it.

MR. HACKBARTH: Isn't that sort of how markets work, too? You can't really gain any competitive advantage if everybody's getting better.

DR. CHERNEW: That's right, but the point is the bonus system, that has a different price mechanism that sorts that out in a way that the bonus system doesn't necessarily.

MR. BUTLER: You know, it's interesting.

Employer-based plans are aggressively moving to carrots and sticks that engage the beneficiary in helping achieve some of these measures, like screening and cholesterol and all of those things, and actually financially motivating people to do that. That really is -- it's another part of the beneficiary's, you know, shared decisionmaking and engagement. Has that ever been considered a possibility under --

MR. ZARABOZO: Actually, part of the comment letter that we alluded to, in addition to commenting on the star system, we had a couple of comments. One of them was on the decision of CMS not to allow tiered cost sharing, so that, for example, on the benefit design where you would say we're going to waive all co-pays for this segment of the population, that would not be permitted under the proposed regulation. So we said, well, maybe you shouldn't have this blanket prohibition, you should allow some flexibility so that you can use the co-payment mechanism as a way of encouraging people to do what you want to encourage.

MS. BEHROOZI: Very quickly, the bonus program will apply to employer group plans the same as others?

MR. ZARABOZO: Yes, because a lot of the employer

group plans are a plan within a contract number, so that -- I mean, that's -- yeah, most of the enrollment is -- yeah.

MS. UCCELLO: Yes, can you just give me a little more background on this prohibition from using medical record review? I didn't get what that was.

MR. ZARABOZO: Yeah, the PPOs were not allowed to use medical record review to report on the hybrid measures.

MS. UCCELLO: Rationale for that?

MR. ZARABOZO: Well, one issue might be from a PPO point of view. If you have out-of-plan utilization, it's difficult to get the medical records. So, I mean, that made it clear that you could not compare those plans to HMO plans in a sense. Only on the measures that involve only administrative measures could you make a comparison.

DR. BERENSON: Yeah, I want to talk a little more about the genesis of this demonstration. It has the earmarks of an earmark. And I guess my question is I thought that there's administrative rules that OMB set up about budget neutrality in demos, and what the ACA did was give exemption for the innovation center, because those rules are often sort of frustrating to real demonstrations. But here we have something that may not be a real

demonstration, and so I guess my question is: Is that right, that this had to go through a review for budget neutrality?

MR. ZARABOZO: It had to go through a review, yes. But I think that budget neutrality is not a requirement.

DR. BERENSON: It's not a requirement --

MR. ZARABOZO: Demonstrations, is my understanding of the situation here.

DR. BERENSON: I thought that was always the frustration that people had in trying to get demonstrations through OMB, that that was an administrative requirement, not a legislative requirement. So in this case they found a reason why -- perhaps some justification that the quality improvement would reduce cost or -- I guess my question is: This was not exempt from that normal administrative process.

MR. ZARABOZO: No. It was reviewed, yes.

DR. BERENSON: Okay. That's what I'm asking. Okay.

MR. HACKBARTH: Related to that, so the hypothesis is that by extending the bonus payments further down the continuum, that will help improve quality. I guess my next question is: How would they know? What's their control

group here that they're going to say, oh, these people had to broaden the incentive, these people didn't. How do they know whether there's been any change as a result of this demonstration program?

MR. ZARABOZO: Usually they hire a contractor to figure that out.

I guess they could use historical information about a particular plan to say that this is how they progressed over the years. We instituted this program. They seem to have improved --

MR. HACKBARTH: That would be a really lame --

MR. ZARABOZO: Well, I'm just -- I mean, this is just hypothetical on my part. I don't know exactly what they're planning in terms of that.

MR. HACKBARTH: I'm obviously not going to put you on the spot. As Bob says, this really doesn't look at all like a demonstration. This is fairly transparently a way to give more money to plans, and that's distressing.

DR. KANE: Metrics on page 6, basically the HEDIS, HOS, and CAHPS. I gather HOS is a survey of Medicare beneficiaries.

MR. ZARABOZO: Right.

DR. KANE: But the other two, are they at all -- they can survey anybody --

MR. ZARABOZO: Oh, no, HEDIS is used throughout the industry.

DR. KANE: It's not just -- in fact, it's not Medicare.

MR. ZARABOZO: Not just Medicare.

DR. KANE: It might even not be Medicare. How do we know how much Medicare -- because, I mean, most people feel that managing the Medicare population is different than managing the under-65 population?

MR. ZARABOZO: Well, the measures are -- there are Medicare measures -- there are measures that are exclusively Medicare, measures that are exclusively commercial, and measures across -- and then Medicaid is there, SCHIP is there.

DR. KANE: And so the HEDIS measures --

MR. ZARABOZO: The HEDIS measures we talk about are the Medicare population HEDIS measures.

DR. KANE: And so the 15 clinical quality metrics are just for Medicare beneficiaries.

MR. ZARABOZO: Only the HEDIS measures that apply

to Medicare, right.

DR. KANE: But are they -- okay. So they might also -- they wouldn't include then the results of those measures --

MR. ZARABOZO: No, no. We're talking only the results for the Medicare population.

DR. KANE: Okay. So the clinical, at least it's only Medicare. And then the same thing for CAHPS or not?

MR. ZARABOZO: Right. CAHPS is a variety of settings in which CAHPS surveys are made.

DR. KANE: But is the results that go --

MR. ZARABOZO: The results -- we're only talking about the survey of the Medicare --

DR. KANE: Medicare.

MR. ZARABOZO: -- MA enrollees and then the survey of the Medicare fee-for-service enrollees.

DR. KANE: Okay. So that's specific to --

MR. ZARABOZO: Right.

DR. KANE: And then the second question I had is your comment that they allow for missing measures -- or I guess they just ignore them. How many missing measures can you have before you don't get --

MR. ZARABOZO: You have to have half of the measures present, so 26 out of 51 --

DR. KANE: But you can pick whichever 26 you want or is there --

MR. ZARABOZO: No. If you fail to report a measure that you should be reporting, you are given one star. You can't say, "I don't feel like reporting this measure," and get -- you know, that's not counted. You get one star for a measure that you should have reported. If an auditor says materially biased or something wrong with this measure, you get one star. So some measures, for example, private fee-for-service plans are not required to report these measures, so those measures are not present. For some HEDIS measures you do not have enough of a population covered by that particular measure to be able to report. So that's why you can have missing measures.

DR. KANE: Is that the only excuse for what you can be missing a measure, you have inadequate cell size -- not enough -- or can you --

MR. ZARABOZO: On HEDIS, probably on HEDIS, that would be it, yeah.

DR. KANE: Okay, thanks.

MR. HACKBARTH: Kate, clarifying questions?

DR. BAICKER: Yes, I had a question on the aggregation of the measures. My understanding is that they're just an average, a simple average over all the measures. So then I'm curious if you have any sense of which measures are actually driving the variability in the outcome. Each one may be entering equally, but if there's no variation on some of them, then the other ones are going to be the drivers of who's in which bin.

MR. ZARABOZO: On that point, as we mentioned, the intermediate outcome measures have a lot of variation, and they're a large part of the HEDIS measures included in the star system. If you look at the administrative measures, there's quite a bit of variation there, too, in the measures. So that may merit more looking at, what's the variation occurring here on these administrative measures. Some measures have very little variation.

DR. STUART: I would like to follow up briefly on a point that I raised last night, and that is, the strategy of MedPAC with respect to the coming availability of encounter data after 2012. And I'm wondering whether the Commission is taking an active role in terms of such things

as saying, well, these are the analyses that we would like to see, and so that has implications for the way the data are being collected and the timing in which they'll be made available, or whether we're just simply waiting for CMS to do whatever they're going to do, and then we come in at that point.

MR. ZARABOZO: Well, we have been talking all along to the CMS people. In terms of the data they were requesting, we were kind of waiting for the opportunity to help with that discussion. So I expect we'll continue to talk to them and talk about what kinds of analyses we would like to see, maybe. I don't know. I can't really --

DR. STUART: Is there thinking internally in terms of the kinds of analyses that you'd like to do? Because that's going to have an implication in terms of, you know, the types of data you'd like to have.

DR. MARK MILLER: Carlos, feel free to start, but --

MR. ZARABOZO: Well, I'm thinking -- I mean, almost every discussion we have here in non-MA sectors is what do the MA plans do. So, you know --

DR. STUART: Without belaboring it, if we want to

do everything with it, then obviously that's not going to be possible. And so I guess maybe the real question is whether there are some priorities here that we would like to see and what some of the inherent difficulties that we would anticipate having encounter data as opposed to claims data.

MR. ZARABOZO: Although a lot of the encounter data is essentially claims data.

DR. MARK MILLER: That part of the comment kind of threw me. I mean, I think the first pass at this is -- and you're saying it's everything, but I think our first pass in thinking about this is looking at the relative utilization across these sets of services. This comes up repeatedly, you know, particularly in the post-acute care sector, of what do MA plans do with this particular service. So I think in terms of priorities, a first pass was just looking at the utilization and contrasting it between fee-for-service and managed care.

I've been operating under the assumption that this looks a lot like claims data and that would enable us to do that. But, Carlos --

MR. ZARABOZO: And that's our impression, too. It's pretty much claims data, what we're talking about.

MR. ARMSTRONG: Just to clarify first one point. You describe a concern about in certain circumstances up to 50 percent of the reported information would be administrative rather than clinical quality measures, your point there being not that those administrative measures aren't valuable, just that we're talking about clinical rating and we just need to be aware that in some cases there could be significant influence from measures that actually have nothing to do with the clinical care. Is that right?

MR. ZARABOZO: That's correct. That's the point, yes.

MR. ARMSTRONG: Okay. The second question I had was that you looked at the variability of results. My experience is that MA plans that work closely with regional care delivery systems that innovate as a result of that are plans likely to have higher results. I'm wondering if you've done any evaluation of a measure that's along that kind of line.

MR. ZARABOZO: You mean plans working --

MR. ARMSTRONG: Well, for example, I'm thinking about the Alliance of Community Health Plans, these regional plans around the country that distinguish -- I don't know

actually how you would measures this feature in particular, but distinguish themselves as either owning, but in most cases not, actually having a fairly close relationship with the regional or the local care delivery systems, and as a result, innovating in ways that purportedly -- and I think the evidence would show actually -- does drive better scores against these measures.

Did we try to affirm those kinds of features?

MR. ZARABOZO: You can look at, for example, performance by corporate entities, and so the national health plans, some of them are not very good performers, and you can do it on that basis. If you would like, we can do that kind of comparison, a more local plan, how do they compare to the national plans or plans that are present in many areas and many of them new to an area. We can do that kind of comparison.

MR. ARMSTRONG: Okay. Thanks.

MR. HACKBARTH: So what I hear you saying, Carlos, is that there's not really granular information to consistently and systematically distinguish among plan types and how they're organized and how close the relationship is with the delivery system. You know, there's a lot of

variety on those variables that isn't systematically captured.

MR. ZARABOZO: We could do something like non-chain plans versus chain plans or something like that. The other --

MR. HACKBARTH: Yeah, but those are real loose --

MR. ZARABOZO: -- part about what kind of plan we're talking about, we don't really have that kind of -- it would take some digging to --

MR. HACKBARTH: It used to be --

MR. ZARABOZO: -- categorizing -- I'm sorry.

MR. HACKBARTH: It used to be when we talked about group and staff models as compared to others.

MR. ARMSTRONG: Right.

MR. HACKBARTH: But I'm not even sure that those categories are as meaningful as they once were. A lot of those plans, you know, develop networks and, you know, IPA-like delivery systems.

MR. ARMSTRONG: It just seems to me -- I know at least my experience is we work backward and we just look at the top 20 plans.

MR. HACKBARTH: Right.

MR. ARMSTRONG: You know, features or characteristics of those plans kind of emerge. But it just seems to me that part of the work we're trying to do, even when we talk about, you know, looking at how post-acute services work or doesn't work or whatever we might be looking at, it's to cull out, well, what are those characteristics of health care systems, including both the benefits, but also then the care delivery itself, that kind of rise to the surface that end up driving distinctive results like these.

MR. HACKBARTH: Yeah, I think the question is a great one. The issue is whether the data that's collected allows us to effectively do that analysis.

Okay. Round 2.

DR. CHERNEW: I think our discussion of all these quality things is important, and I'll say a few more things about that in a minute. But one thing that we haven't discussed much that I think is fundamentally important is the material in the chapter -- and you alluded to it briefly -- the sort of flaws in the payment model going forward with the sawtooth graph that arises. So I just want to put in a plug for us thinking about how to continually emphasize that

point, because it's something that really can be done. A lot of this measurement stuff has a lot of problems. We're not sure how to do it. I don't know if there's a right way. But I think we -- I guess I'd like sort of a quick answer if you believe that there really is a fundamental problem that we could probably solve relatively easier than we could solve some of the quality measurement issues of which there's difficult choices and difficult measurement issues. Is that loosely right? The sawtooth graph that you show is pretty convincing. That's the problem with the quartiles.

DR. HARRISON: Right. We sort of suggested something that you might do by sort of creating different floors and ceilings, in effect. But I'm sorry, you want to go on to the quality --

DR. CHERNEW: Well, I will say something about quality. I just wanted to make sure that we didn't lose the emphasis on that and have some discussion maybe as we go forward about the details. I think your solution is fine. There are probably six different ways you might solve that problem, and that's one.

DR. HARRISON: Right.

DR. CHERNEW: But I don't want -

DR. MARK MILLER: This will go in the chapter. We'll say this is a problem, here are some ways you can solve it. We will stay on the case and keep, you know, monitoring this. I suspect once the environment sort of figures this out, it's going to start moving of its own accord.

DR. CHERNEW: That would be good.

DR. MARK MILLER: Well, that might require monitoring as well.

DR. CHERNEW: My comment on the quality stuff was that I do think there's a big issue with how performance is risk adjusted. We have to understand that for many MA plans, they're sharing the delivery system, writ large, so it's not simply the plan. Measuring quality of a plan is fundamentally different than measuring quality of a hospital in a certain way or measuring quality of a physician group in a certain way, because they're sharing the system overall. And many of these HEDIS measures and some of the other measures are very subject, I think, to issues of risk adjustment, as you allude to, but some of the socioeconomic factors and things that matter really are important for how the plans end up doing, and I think increased attention to

that -- it's mentioned there, but it's mentioned with disability, but there's a series of other things.

Right now, for example, I don't think the quality measures at all are risk adjusted in any meaningful way. You just note that there's compositional issues. But the star system doesn't do any risk adjustment or any --

MR. ZARABOZO: Right, the HEDIS measures are not risk adjusted.

DR. CHERNEW: And I also think it's -- I guess the last question I would have is: I think it's important to harmonize all of this with what's going on in other sectors, so this is just one performance measure program. The private sector has a whole series of other ones. The use of HEDIS is helpful because many plans use HEDIS-type measures, although as you know we're only using a subset. I don't know of any other plans that use like the HOS data to do their --

MR. ZARABOZO: The VA has a survey like that, the HOS, but I don't know of its use elsewhere.

DR. CHERNEW: And do you know if there's any attempt to harmonize this type of system with other Medicare programs, say when they measure quality in an ACO? I know

we're waiting on the regs, but it would be nice across different systems, because providers could be serving managed care patients and be part of an ACO and have contracts with the commercial sector; and if they all have different weights and systems and scoring, it's a little bit harder.

MR. ZARABOZO: I think in the fee-for-service, like in the physician practice group demo, didn't they use HEDIS kind of measures? Yeah.

DR. MARK MILLER: But, Carlos, what I would have thought you would have said is that what we did do -- and I'm not forgetting which report, but we did try and give some direction for CMS how to harmonize and measure between fee-for-service and managed care. You're correct that at that time we weren't focused on the ACO angle on all of this, and there was a lot of direction that you and Carlos -- the Commissioners and Carlos put together, and John put together to kind of direct CMS on that issue. But it was also, if you will recall, a pretty heavy lift. There were a lot of issues that had to be kind of brought into alignment.

MR. HACKBARTH: I want to pick up on your first point. It seems to me that there's sort of three broad

categories of measures. There are some clinical measures that are most strongly influenced by the providers in the community, and to the extent that we have health plans with overlapping networks sharing the same providers, you would think that within a given market, there wouldn't be too much dispersion on those measures because they're using the same providers.

Then there might be other quality measures where the plans have a greater opportunity to differentiate themselves because their way of influencing them is through the member contact and, you know, getting members to seek out certain types of preventive services. And then there's the administrative measures where clearly plans can differentiate themselves. And, you know, you'd almost want a little more finely developed strategy for making comparisons, rewarding bonuses, focusing on things that are more within their control, and not having the differences diluted by things that really they don't control at all.

DR. CHERNEW: And, of course, they can select their providers in various ways as well but [microphone turned off].

MR. HACKBARTH: Yeah, that's true. Good point.

It's tricky stuff.

MR. BUTLER: Scott, you make some good points about understanding the characteristics of plans that are performing at the top level. I think there was a chance to marry that to -- I know at the beginning of the year we talked about looking at high-performing health systems and what their characteristics are, which it starts to come together with yours. And it's part of the same dialogue, and I think it's something we ought to think about, not just looking at the plans over here and the systems over here, but how they are in this world of aggregation that's occurring. It would be good to understand systems that are performing at a high level.

MS. BEHROOZI: I'm glad Scott mentioned the issue about the administrative measures because, you know, the way it's put out there in the paper is it's of concern, and I think we should be clearer about what we mean. I mean, I think to beneficiaries things like how long they have to wait on the phone and whether there's an interpreted available for them in their language is critically important. And, you know, when I go on Medicare, Compare, whatever, I want to know that stuff as a beneficiary.

Whether that should be as important a component for purposes of bonuses because that's sort of basic good business practice the way you attract clients kind of thing, it seems -- right? -- that's another question. And so I wonder if we could consider recommending separating out the clinical measures and the administrative measures, not dropping the administrative measures, taking them into account in some form, weighting them less, whatever, so that not only will you achieve maybe a more appropriate or what we have in mind as a balance between clinical and administrative, but also if you have plans that don't have enough of the clinical measures, it'll be more evident rather than having their total kind of bolstered by the fact that they've got the administrative measures. I took that as one of your concerns as well.

MR. HACKBARTH: I really like that point, Mitra. One way to think about it is distinguish between things that are measured and reported as opposed to things that are measured, reported, and linked to bonus payments.

I think the market works pretty well in terms of the administrative measures. If you provide beneficiaries information about, you know, where you have to wait a long

time and various service elements, people can readily digest that information and vote with their feet, and plans that do well will get more revenue, and plans that do poorly will get less.

What is more difficult for beneficiaries or patients in general is to make sense of this clinical performance stuff, and the market may not function as effectively and fluidly and getting more revenue to the good performers, and, therefore, having bonus payments through the payer, there may be a more compelling need for it. It seems like some more refined thinking along the lines you're describing could make this more useful and effective. In a way, we're paying double bonuses for administrative things where plans are already getting rewards through the pretty well functioning marketplace.

DR. NAYLOR: I probably need a civics lesson, but are we able to simulate -- and this might have been a Round 1 -- the PPACA provisions and impact on total Medicare budget and what we're estimating now that we're using different thresholds in terms of the star system, et cetera, on total Medicare budget? And that might have been in --

MR. ZARABOZO: That's that last slide. It costs

$1.3 billion as compared to the star system under the demonstration. It adds an additional $1.3 billion for --

DR. NAYLOR: Okay. Thank you.

MS. UCCELLO: I agree with a lot of what people have already said, but I'll kind of piggyback on or combine Mike and Mitra's comments that the more we move to a more clinically based measure or index, the more important some of the risk adjustment is.

MR. ZARABOZO: I would like to add there that CMS recently at a conference said that they were looking at the issue of weighting of the measures and also how to deal with special populations, or something like that, I mean, you know, tending towards. There may be some risk adjustment issues here that we need to consider.

DR. BERENSON: I have one comment related to Scott's work and then one related to the quality demo.

It's helpful to now see where the plans' risk scores are and to point to the difference between fee-for-service and MA coding and the fact that we'll now get encounter data and can recalibrate within MA. But my concern is related to the Dartmouth study that shows that if you take the same beneficiary and they relocate, they get a

different coding score. They haven't changed their health. And that sort of picks up on previous MedPAC work related to episode groupers that found for, I think, a couple of plausible reasons that you get different scores in different parts of the country, partly because of more exposure to the health system, but maybe partly because of different coding practices.

I guess it brings into some question whether there needs to be ongoing and important refinements of the risk adjustment model. And I guess my question, which I could have asked earlier but I'll ask now, is: Is there work going on in that area? What has been the reaction to the Dartmouth kind of study? I mean, because we're going to be using this for ACOs. I mean, we really need to have a very accurate risk adjuster.

DR. HARRISON: I think the focus is still on collecting diagnoses. I mean, eventually if they move it within the managed care model, you would probably see less variation across the country within managed care plans than you do in fee-for-service, so that may help a little. But that's probably the extent of it.

DR. BERENSON: But no work that you're aware of,

like on making an adjustment for coding, a geographic adjustment even for making -- just like the fee-for-service to MA adjustment, a geographic adjustment or --

DR. HARRISON: No, but remember that the county rates are standardized for the average risk that you see in the county. And, you know, there are problems. You could see that -- I think Miami's risk score is over 1.3. You know, some of that probably came from excess utilization.

DR. BERENSON: Yeah.

DR. HARRISON: So Miami's rate is standardized for that, but when you build a broader model across the country, it's not adjusted like that.

DR. BERENSON: Okay. Related to the quality program, picking up a little bit on the conversations that Scott and Glenn were having, from my knowledge if you look at the top 20 or so MA plans, they are either -- they have close relationships to the delivery system or they're located in particular geographic areas where the underlying delivery system produces, regardless of what the plan is doing. And so to me the best example of where they come together is the fact that if you look at the Southeast, there's almost universally poor performance except in

Tallahassee, where there is an exemplary health plan that has a close connection to its delivery system and scores 1 or 2 in the country.

So I think because of the importance that you've alluded to, Carlos, the importance of geography, because of the importance of geography, I guess I'm a bit of a contrarian about having a model that only rewards the top plans, which may have as much to do with the underlying delivery system than it does to the incremental benefit of the plan. And so to me this is an area where a pay-for-improvement strategy to complement pay for high performance -- I mean, at the high level. I don't think you can just do pay for improvement. If CMS had come along with a demo to sort of try to move plans that were mediocre performers to being significantly better and had had a bonus system associated with pay for improvement, I could have seen this as potentially even a demo, not just a way to get money out the door. They haven't done that. They've just sort of lowered the bar. But I do think as we at MedPAC think about quality and rewards in the MA program, we should focus on the things that plans -- the incremental benefit that plans can provide, which is why I actually like the idea of

administrative measures being in here somewhere. And those measures which typically I wouldn't support, like process, particular process measures around prevention, I mean, I think in general MedPAC has a view that we should really be focusing on major outcome measures, and I sort of believe that. But if, in fact, the outcome measures that we have would largely be a function of the underlying delivery system and not the plan, then maybe in this area it is reasonable to focus on those HEDIS measures, health of seniors, and administrative measures that we can attribute to the plan, and to think about maybe pay-for-improvement strategies, not just pay for performance.

DR. MARK MILLER: I don't have any issues with the notion of pay for improvement, and particularly as you're starting something off, you may want to do that. You may want to keep it in place, you know, over the long haul.

I would also just ask, when we have this discussion about the underlying delivery system versus what the plan can do -- and I know you're not saying this. There is always this concern that it's like, well, it's the underlying provider system, and so the plan shouldn't be held responsible, and I know you wouldn't go that far. And

I would just ask us to look hard at some of the outcomes measures, because readmission rates, use of emergency room, you would hope, even in a poorly functioning provider underlying network, that a plan could bring some movement to those types of things. So I would not retreat immediately to the HEDIS stuff and say that's all we can do. I would ask that as a Commission you guys pay some attention to the outcomes stuff, and the ones where we think, you think, that the plan can actually have some impact on, because it seems like there are some.

DR. BERENSON: I agree with that. I think of readmissions as sort of an intermediary outcome as opposed to mortality, which to me would be a real outcome. But I absolutely think -- but in that context, I'd be interested in perhaps rewarding a plan that had a 20- or 22-percent readmission rate and could under its auspices get it down to 17, even if that wasn't in the top tier nationally. I think that would be a reasonable approach.

Again, I don't think you can overweight the improvement. You don't want to not reward the good plans, but finding some balance. But I'm with you. I think we've got to go measure by measure and try to figure out whether

we think that's a measure that the plans can influence. I think even in an area with poor clinical quality, plans can make a change, can influence what's going on. And so I wouldn't say that there's a whole bunch of measures that are off limits. I just sort of think I like the improvement paradigm in that situation more than just hitting a standard.

DR. MARK MILLER: And I agree with you that mortality [off microphone].

DR. KANE: I just want to ask a little bit about the philosophy around where socioeconomic metrics might come into this, especially if you start thinking about some of the plans that are, you know, sort of closely associated with poorer communities as they start to -- some of them specialize in, actually, poorer communities. Is there any differential acknowledgment or risk adjustment that goes into that? I mean, you don't want to encourage worse performance just because the underlying community has low socioeconomic metrics, but you also want to acknowledge that they might be starting off some of these measures with a population that's just much less amenable to doing the right thing.

So, you know, between language and support systems and beliefs about or, you know, distrust of the health -- there's a lot of metrics that require a pretty highly educated person who's willing to be compliant. So I guess that's one of my concerns about the quality in particular, or any kind of adjuster when we're trying to, you know, change the way the payment works based on how they perform, whether there's some accommodation for the fact that they might be working with populations that just aren't as easy to work with. Granted, they should be improving and trying to get up the scale as fast as everybody else.

MR. HACKBARTH: We talked about this a little bit yesterday, and I think that's a really important issue. It cuts across all of the quality measurement, pay-for-performance efforts, not just MA but all the individual provider sectors as well. And I think you well describe sort of the tensions that exist. On the one hand, you don't want to say, oh, poor quality is good enough for people in low socioeconomic circumstances, for example. On the other hand, there are differences in the challenge faced.

DR. KANE: Especially if the money starts to change based on -- I mean, that's where you start to worry

that, okay, you're scoring low but, you know, you're in a tough neighborhood. It's like schools with low education scores. So how do you deal with that? Do you give them less money? I mean, because they're in a poor community. So, you know, I just hate to see the payment system start to perpetuate mediocrity because the money goes to the places that have the resource to do --

DR. KANE: Yeah. So I think that's an issue we're going to inevitably need to come back to and talk more about in a variety of contexts.

DR. BAICKER: I would just echo Bob's comment that it's really important to get high-quality risk adjusters, especially in thinking about the geographic variation. I know dabbling in this field we're stymied by the fact that the risk adjusters that are available are clearly affected by the geography, but using no risk adjuster is the wrong answer, too. And so you're left with very wide bounds on lots of things. It's somewhere between no risk adjustment and wildly over risk adjusting. It seems important when thinking about changes versus levels in quality. Clearly you want to reward improvement. You also want to reward excellence, and that gets into some of the issues we talked

about with ACOs, that if you have a one-sided bonus, then the smaller entities that bound around a lot are going to get bonuses but not penalties for the movement, and you want to take into account size as well. So it opens up lots of issues, but I think you do want to reward both investment that produces effort and excellent in care provision.

The last point I wanted to raise was thinking about the weighting of the stars that you mentioned. I would imagine that the reason all those inputs are weighted equally is because that's seen as neutral in some way. But, of course, equal weighting isn't neutral. It's a judgment just as much as any other weighting of the stars is a judgment. And it seems -- I would doubt that putting equal weight on all of those measures was actually the way to produce the highest quality outcomes in the metrics that we really care about. So I would urge a reevaluation of that equal weighting of all those criteria that are clearly not equal inputs into things that we want to be rewarding.

MR. HACKBARTH: And as I recall, in the hospital pay-for-performance program that was just announced, there too the approach was equal weighting. And I think it is a default, but it can be a default that leads to problems.

The one time I can recall that we grappled with this issue of how to weight was around home health measures, and this was like four or five years ago when we were first starting about pay for performance. And we talked some about whether these measures should be equally weighted or not, and you very quickly get into some really tricky issues that are not easy to answer.

So I understand why people do default to equal weighting, but as Kate says, you know, that's a judgment on its own, and you end up with some potentially perverse results.

DR. STUART: I'd like to raise something that we've talked about in the past, but it hasn't come up here, and that is, the problem of kind of teaching to the test. Any system that you develop for measuring quality or rewarding -- particularly when there are rewards based upon quality measures, then plans have a very strong incentive to look good on the measure, and they may have a less strong incentive to look good on other kinds of things that aren't being assessed. And I think that just comes with the territory, and we just need to be aware of it. But it also tells me that it would be very useful to have kind of a

back-up, maybe a shadow system by which we could measure quality in areas that are not being captured by these measures and use that as kind of a sensitivity test as we go forward in the development of these pay-for-performance systems.

And I'm just taken with the presentation that we had yesterday on physician services and assessing ambulatory quality using a measure that would developed by MedPAC, this MACIE measure that has 35 or 37 different measures of ambulatory quality. And when those encounter data become available, then this is something that one would be able to do. And so this gets back to the earlier point about, you know, having some ideas about how you would use those data, and this would be something that I think should have relatively high priority.

MR. HACKBARTH: When does your second term end, Bruce?

[Laughter.]

MR. HACKBARTH: Hopefully you'll be here for the day when the data arrive.

DR. STUART: The timing may not be good [off microphone].

MR. ARMSTRONG: Just briefly, I would add that I really appreciate many of the comments made by others. I particularly like the position that MedPAC's taking and the way we're describing it on this so-called demonstration, the extension of the bonus, which is and should be concerning.

I think the only additional points I would make would be that the desire to measure these kinds of things is obviously to advance improvement and to improve the care beneficiaries are receiving. I don't know how far MedPAC should go with this, but I do think that this goes beyond measuring comparative scores of the plans. But it also is around how do we engage in local communities and more transparently and comparatively reporting the performance of the plans, of the providers, so that employers and individual subscribers and others have access to this information and it becomes actionable at a whole series of other levels as well?

I know we identify issues and we try to improve the effectiveness of these measures. As we do, let's also think about how we can extend the application of these and make these kinds of metrics really even more powerful.

DR. BORMAN: I don't have the sophistication to

look at this from sort of the plan administrator level or some high up level. But as I sit here and think about this from the patient and the provider, the care deliverer level, particularly the physician or other allied health care professionals interacting one on one, particularly in an office setting, and I think about, you know, it's not just true for MA, one of the things that keeps hitting me is that we need to keep pressure on the notions of interoperability and standardization, that we've got to have all of these systems, whatever facet of the program, that we're measuring in and whatever qualities we want to do by and whether it's administrative or clinical or whatever, we need to be looking for things where there's overlap to make them the same, where there's -- and where we're asking parts of a system to talk to each other, let's make it interoperable. I think as people, particularly on the small business side, which many existing physician and other professional practices are, the cost of the electronic things that will facilitate this evolution is somewhat daunting, you know, the EHR monies notwithstanding. And I think we just need to keep front and center in each of these discussions, not just MA, about interoperability and standardization of measures

where -- overlapping measures where possible.

MR. HACKBARTH: Bob's and Kate's comments about the importance of continuing to improve risk adjustment make me think about this, sort of the next -- a potential breakthrough in risk adjustment could come from computerized medical records and having quick, easy, low-cost access to clinical information, as opposed to just claims type information.

That's not to say that we shouldn't be trying to improve the systems with the data that we currently have. But that could be like a huge improvement opportunity. Is anybody working on, oh, once we have that data, here's how risk adjustment will change? You know, there are organizations -- Kaiser Permanent for one has a huge database that could now be used to start developing the risk adjustment system of the future. Is anybody working on stuff like that?

DR. BAICKER: I have just a tiny piece of information, my impression not hugely well informed, is that even getting lab values back from labs that we pay for would go a long way in adding a less -- "gameable" is a strong word, but a less endogenous measure of patient well-being

and that that is relatively simple to attach to claims, because you're already paying for that line item, and that it's pretty predictive of patient severity.

MR. HACKBARTH: Yeah, we actually made that recommendation, I think like three years ago now -- unsuccessfully to this point.

DR. MARK MILLER: And there is some -- you know, I'll call it junior varsity things that we can do with the existing data. Another poor choice of words, I guess. But I think one thing we can do is look at the variation across the country and just the numbers of codes, and, you know, perhaps that gives you something of a poor man's adjuster, but it's not -- I mean, immediately anybody who's into this sees the problems with this.

Then the other thing is to take a look at the existing HCC and see how it does for specific populations and specific -- because, you know, in general, it's got an inaccuracy. But looking at the tails of the distribution and see if there's improvement there. That doesn't deal with the geographic issues, but it does deal with some of the precision issues.

In general, you know, in the mean and the

distribution and the average, there's a certain accuracy there, but how does it do with specific types of patients? We did some looking at that, and we can kind of go back and take another look and see if there's any more tweaking that could go to that.

MR. HACKBARTH: Okay, we are done. Thank you, Scott and Carlos.

We'll now have our public comment period.

[No response.]

MR. HACKBARTH: Seeing no commenters, we are adjourned.

[Whereupon, at 11:50 a.m., the meeting was adjourned.]