MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 6, 2012
10:19 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
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CRAIG SAMITT, MD, MBA
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AGENDA PAGE

P R O C E E D I N G S [10:19 a.m.]

MR. HACKBARTH: Okay. Would you take your seats, please? So judging by the number of people in the audience, people know that we are considering draft recommendations on updates to the Medicare payment rates at our meeting this week. These are draft recommendations that I am offering for the consideration of the Commission. Based on the conversation at this meeting and subsequent conversation I have with individual commissioners one on one, we will formulate final recommendations for a vote at our January meeting.

As a reminder, by statute, by the statute that created MedPAC, we are to recommend to the Congress payment rates that are consistent with the efficient delivery of health care services after considering the budgetary impact of those recommendations. In no case, in my view, should we recommend rates that we think will impede access to quality care for Medicare beneficiaries.

In formulating our recommendations, we do use a multiple-part payment adequacy framework, and, Kate, am I stealing things from you? And we will go into that in more detail as we go through the individual presentations.

In formulating our updates, what we do is what we refer to as "begin at zero." As people in the audience know, under the Medicare law, updates are written into the law as market basket, say, minus productivity or a factor like that. We use a different approach. We are making recommendations not out into the future but for one year at a time, and in formulating our recommendations, we start with the rates that are currently prevailing for the provider, say, for hospitals. And we're formulating a recommendation on whether that current prevailing rate should go up or down.

In making that recommendation, we take into account what is projected to happen with input prices as well as a number of other factors in our payment adequacy framework to be discussed in more detail later on.

The important point for now is that when we recommend an update or a decrease, it's based on evidence that that movement is the appropriate way to go consistent with our statutory responsibility to recommend rates consistent with the efficient delivery of services.

Now, Kate, I think you're prepared to talk about the effect of the sequester and how it plays into this. Let

me turn it over to you.

MS. BLONIARZ: So a consideration in developing update recommendations for 2014 is the Medicare sequester, which starts in February 2013 and cuts 2 percent from nearly all providers. And this chart shows how the sequester works for an example sector.

The sector receives $100 in 2012 and receives a statutory update each June. The yellow line shows the payment in the absence of the sequester, and the dashed green line shows the payment when the sequester begins in February. The updates the Commission will consider today and tomorrow are based on the yellow line, or they are updates to the base rate.

The presence of the sequester will affect the savings estimates for the Commission's recommendations. In the first example here, a sector has a base rate of $100 in 2013 and a statutory update of 1 percent. In 2014, payments increase by $1 for the update and decrease by $2 for the sequester to $99. If the Commission recommends a 1-percent update for 2014, this would result in a payment amount of $101, and compared with the sequester baseline, the Commission's recommendation would have a cost.

The second example shows a sector with a base rate of $100 and a statutory update of 1 percent, and, again, for 2014 the sequestered amount is $99. But for this sector, the Commission's recommendation is a negative 2-percent update, resulting in a payment rate of $98. And when compared with the sequester baseline, the Commission's recommendation would result in savings.

I'll just stop there.

MR. HACKBARTH: So let me just underline a couple points of what Kate said. And, Kate, could you put up the graph?

So one way to think about this is that MedPAC is making recommendations on that solid line and what the slope of that line should be or what the step should be in that line. The sequester runs off to the side. The recommendation that we make, as in the example that Kate provided, may sometimes be higher than the payment amount after sequester, and sometimes it may be lower than the payment amount after the sequester.

Where we're recommending a dollar amount that is higher than the sequester, what we're saying to the Congress is we think that the sequester-based payment amount is too

low and not consistent with the efficient delivery of quality services to Medicare beneficiaries.

Alternatively -- well, I don't need to go through it. When it's the reverse, it's just the reverse of that.

So the sequester I know is important from a provider standpoint, but our responsibility is to make the recommendations on that yellow line and make it clear what we think the appropriate rate should be.

One last comment, not related to the sequester. As we move through our recommendations, there will be three areas where we do not have separate votes: physician payment, skilled nursing facilities, and home health agencies. And the reason for that is that in each of those instances, we have established multi-year recommendations that we've voted on in the past, and the basic circumstances in those sectors have not changed, and so we don't reopen those recommendations for re-vote each year. We will go through all of the normal analysis and have all of the discussion. It simply won't conclude in a separate vote in those three areas.

So, with that as a preface, let's now turn to hospital, and who's leading the way? Zach?

MR. GAUMER: Good morning. This session will address issues regarding Medicare payments to hospitals.

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

This is the first of several payment adequacy discussions you'll hear today. In each case, analysts will present you with the Chairman's draft recommendations, and final recommendations will then be voted on at the January meeting.

The hospital team has a lot to cover today, so we're going to move quickly through it all. There's a more detailed discussion contained in your mailing materials, and, of course, we're happy to answer questions.

We evaluate the adequacy of hospital payments as a whole, meaning we examine whether the amount of money in the system is sufficient. We have a particular focus on trends in inpatient and outpatient payments as well as the

distribution of payments across different categories of hospitals.

In 2011, Medicare spent roughly $158 billion on inpatient and outpatient hospital payments. On a per capita basis, inpatient spending declined approximately 1 percent, and outpatient spending increased approximately 9 percent. Overall Medicare payments to hospitals increased approximately 2 percent per capita in 2011, and a part of this, we observed that payments to critical access hospitals grew faster than payments to IPPS hospitals. However, as you know, critical access hospitals are a small share of total hospital payments.

We believe beneficiary access to hospital services is strong for several reasons.

First, the supply of hospitals continues to increase annually. In 2011, the number of hospitals opening exceeded the number of hospitals closing for the tenth consecutive year.

Second, the breadth of services hospitals are offering continues to expand.

Third, hospitals' access to capital appears adequate. For example, hospital construction spending

remained steady at approximately $26 billion in 2011 and in 2012, and interest rates on debt are at historically low levels.

The trend in hospital inpatient and outpatient service volume remains similar to what you've observed in the last two years. The changes in Medicare inpatient and outpatient volume collectively do not suggest problems with access, but Medicare service volume overall continues to shift to the outpatient setting.

As you can see in red on the slide above, the cumulative change in inpatient discharge volume from 2004 to 2011 was approximately negative 8 percent per beneficiary, or about negative 1 percent per year. By contrast, the green line displays a cumulative change in outpatient services of approximately 34 percent per beneficiary over the same time period, and this equates to nearly a 5-percent increase per year.

The two likely sources of the shift from the inpatient to the outpatient department are:

First, the movement of surgical procedures to outpatient departments; specifically, we observed a decline in inpatient surgical discharges that was steeper than the

decline in medical inpatient discharges.

And, second, we continue to see increases in the number of outpatient observation cases and a corresponding decline in the number of one-day inpatient discharges.

Part of the growth in outpatient service volume is due to a shift in the site of care from physician offices to hospital outpatient departments. For example, in hospital outpatient departments, we see evaluation and management visits up 8 percent per capita and echocardiograms up 18 percent per capita in 2011. By contrast, the volume of these services actually fell in physician offices. This follows the financial incentive we have discussed in prior meetings where Medicare pays substantially higher rates for the same services provided in the outpatient department as opposed to in the physician office.

As we have described in previous sessions, the rates for E&M visits and echocardiograms are both over 70 percent higher in the outpatient setting. Medicare pays more to providers every time one of these services is shifted from the physician's office to the outpatient department, and we estimate that this site-of-service shift has increased payments substantially in recent years.

Hospitals received $1.5 billion more from services that they would have under physician office rates in 2011, and this amount increased by approximately $200 million from 2010 to 2011. Therefore, if this shift in site of service continues, we expect Medicare payments will increase further.

While there's still room for improvement, quality of care indicators are generally improving. We see improvements in 30-day mortality for the conditions we monitor, including AMI, congestive heart failure, stroke, hip fracture, and pneumonia. There has also been some improvement in patient safety and patient satisfaction measures. As we discussed in September, there has been a slight improvement in readmission rates. CMS' readmissions penalty started in fiscal year 2013, and many hospitals report increasing efforts to reduce readmissions. But, of course, it's a little too soon to quantify the effects of these policies.

Craig will now take you through our analysis of payments and costs.

MR. LISK: Good morning. In assessing payment adequacy, we considered the estimated relationship between

Medicare payments and hospitals' cost of furnishing care to Medicare patients. Growth in Medicare hospital payments per discharge under the inpatient PPS depends primarily on three factors: annual payment updates, changes in reported case mix, and policy changes that are not implemented in a budget-neutral manner.

As you can see, per case payments have grown every year over the last decade. Payment growth, however, accelerated in 2008 and 2009, largely due to increases in reported case mix that was due to documentation and coding changes that took place as a result of implementation of the MS-DRGs in 2008. Per case payments increased, for example, by 5.4 percent in 2009.

In 2011, however, payment growth slowed substantially. This smaller increase in payments was due mostly to a temporary 2.9-percent downward adjustment made to recover overpayments from documentation and coding changes that took place in 2008 and 2009. Per case payments increased an average of 0.7 percent in 2011.

Now we shift to discussing how to correct for documentation and coding changes which have resulted in overpayments to hospitals. As we discuss in detail in your

mailing material, after MS-DRGs were introduced in 2008, hospitals had an incentive to improve diagnosis documentation and coding. They started to code with more detail, which resulted in an increase in payments without a real change in patient severity or the actual cost of care. To make the transition to MS-DRGs budget neutral, we need to offset these overpayments.

CMS and MedPAC both suggested that documentation and coding changes be offset prospectively based on past experience regarding hospitals' responses to changes in DRG definitions. In response to industry concerns, however, the Congress deferred some of the proposed adjustments for documentation and coding until later.

Now, after data became available on 2008 and 2009 documentation and coding, CMS reduced payments in 2011 and 2012 to offset the remaining effects of documentation and coding that occurred in 2008 and 2009. But no changes in rates have taken place to offset changes in documentation and coding that occurred in 2010. An additional adjustment is needed to stop further overpayments and recover past overpayments that have or will occur in 2010 through 2013.

Moving on, in this next chart we compare increases

in hospital costs and input price inflation. In 2011, hospitals held cost growth close to underlying input price inflation. You can see this as both cost growth, represented by the green line, and input price inflation as measured by the hospital market basket index, the blue dotted line, remains close to one another. This is a continuation of a pattern of lower cost growth we have seen since 2009. In a prior period, we observed cost consistently increasing faster than input price inflation, although the difference was declining.

The lower cost growth we observed for hospitals since 2009 is a result of a combination of lower hospital input price inflation, which has been under 3 percent for the last three years, and hospitals also keeping their cost increases close to this lower input price inflation. This lower cost growth may reflect increased financial pressure on hospitals and also uncertainty in the economy.

So what does all this mean for margins? Now, our margin is calculated as payments minus cost divided by payments, and it is based on Medicare allowable costs. The overall Medicare margin covers acute inpatient, outpatient hospital services, plus other hospital services that

Medicare pays for, including hospital-based home health, skilled nursing facility care, rehab services, inpatient rehab, and inpatient psychiatric facilities.

It also includes GME payments and costs of other Medicare-related payments such as health information technology and the low-spending county payments that were in effect in 2011 and 2012.

In 2011, the overall Medicare margin was minus 5.8 percent, roughly one percentage point lower than in 2010. The decrease in the overall Medicare margin from 2010 was primarily due to a drop in the inpatient margin, which fell to minus 4 percent. The decline in the overall margin in 2011 would have been lower if it were not for several temporary payment adjustments that were in place in 2011 and 2012.

Our next slide shows how the overall Medicare margin differs across hospital groups in 2011. The average overall Medicare margin for rural hospitals was minus 3.2 percent, which was three percentage points above the margin for urban hospitals, which was minus 6.2 percent. If we include the 1,300 critical access hospitals, the rural margin would be minus 1.8 percent. Critical access

hospitals, if you remember, receive payments equal to their allowable costs plus a 1-percent profit margin.

Major teaching hospitals continue to have overall Medicare margins that are higher than average PPS hospitals in large part due to the extra payments they receive through the indirect medical education and disproportionate share adjustments. For-profit hospitals have the highest rural Medicare margin, minus 1 percent.

Next I want to move on to discuss the forecast of the overall Medicare margin in 2013, the current policy year. We estimate that the overall Medicare margin will remain relatively steady through 2013, going from minus 5.8 percent to minus 6 percent. So why do we expect the margin to remain steady over this period?

First, payment rates will increase revenues by 2 to 3 percent over the two years. We expect, however, costs to go up more than the payment rates, although we believe costs will continue to go up close to underlying input price inflation.

The expiration of certain special payments at the end of fiscal year 2012 -- the temporary low-volume adjustment, low-spending county payment, and expiration of

the Medicare-dependent hospital program -- will also lower payments relative to the update. So those things go down. But, finally, increases in HIT payments will mostly offset this difference between the payment increase and the cost growth. In 2011, we only had about $300 million in HIT payments, and in 2013, we expect these to total about $3 billion.

Jeff will now discuss our analysis of financial performance among efficient hospitals.

DR. STENSLAND: So Craig has shown that our best estimate of the 2013 Medicare margin is negative 6 percent. However, this is dependent on costs continuing to grow at roughly input price inflation. In the past, we have shown that hospital costs depend in part on the level of financial pressure faced by the hospital. For example, in your mailing material, we stated that hospitals under the most financial pressure have costs 8 percent below the average. Those that are in the best financial shape have costs that are 4 percent above the average.

Another example that is unique to this year is small rural hospitals with under 50 beds. In 2011, their payments per case increased by an average of 8 percent due

to a new low-volume adjustment that was added. Their costs then rose that year by 7 percent, well above other hospitals. This raises the question on average how much pressure are hospitals under to control their costs this year and going forward.

Here we show three indicators of hospitals' all-payer financial condition: their total all-payer margin; their operating margin, which excludes things like investment income; and EBITDA, which is a cash flow measure computed as earnings before interest, taxes, depreciation, and amortization.

The point of this slide is to show that after all-payer margins fell in 2008 -- we note that Craig said that hospital costs tended to go up at a slower rate. However, the graphic also shows that all-payer margins rebounded from 2008 back to close to historic highs in 2010 and 2011. So given that their all-payer financial performance is strong in recent years, one possibility is that this rebound in financial performance may result in higher cost growth in 2013. However, it's also possible that hospitals will continue to restrain their cost growth due to limits on Medicare updates, declining Medicaid payment rates in some

states, and additional uncertainty regarding uncompensated care costs going forward.

We do hear reports that many hospitals have set a goal of bringing their costs down to Medicare rates, but there is some uncertainty as to the rate of cost growth going forward.

To illustrate the differences in cost across providers, we've created this chart of hospital standardized inpatient costs per discharge. The costs are standardized for case mix, local wages, interest costs, teaching costs, and the share of Medicare patients on SSI, as well as outlier cases. The median standardized cost per discharge is $11,500. However, what I want to highlight here is that there are hundreds of hospitals with standardized costs that are 10 to 15 percent lower than the average. These are hospitals with a standardized cost in the range of $10,000 to $10,500. So it's clear that some hospitals can do well on cost, but simply having low cost is not what we would call efficiency. Efficiency requires a high quality of care at a low cost. The question is whether there are hospitals that can do relatively well in the combination of cost and quality.

And that brings us to what we call our relatively efficient hospitals. To determine who is efficient, we use the same criteria as the last couple years. I will not go into them in detail, but hospitals are categorized as relatively efficient if they perform relatively well on a mix of mortality, readmissions, and standardized inpatient cost per case in three straight years -- 2008, 2009, and 2010. After identifying who historically has done well, we then look at how well they performed in 2011.

Here are the results. We ended up with a group of 297 hospitals that have historically been relatively efficient providers for three straight years prior to 2011. This group of 297 hospitals represents about 14 percent of all IPPS hospitals that have usable data over all four years.

If we look at the first column of numbers, we see that historically efficient hospitals had 13 percent lower mortality, 5 percent lower readmission rates, while keeping their costs 10 percent lower than the national median. Lower costs allowed these hospitals to generate a positive Medicare margin in 2011 with a median margin of 2 percent. We also found that 69 percent of patients rated relatively

efficient hospitals either a nine or a ten on a ten-point scale. This is slightly better than the comparison group which received a top rating from 67 percent of their patients. This suggests that Medicare payments are adequate to cover the cost of relatively efficient hospitals, and these hospitals are able to generate care which meets the expectations of their patients.

Before we talk about the update recommendation, I'm going to use this graphic to explain one significant change to Medicare payment policy that will occur in 2014 under current law, and what I'm going to do is I'm just going to walk you down this flow chart from one box down to another.

As part of PPACA, there was a significant restructuring of the Medicare DSH program. In 2011, the DSH program paid out roughly $11 billion of supplementary payments to hospitals with high shares of low-income patients. For DSH purposes, low income is defined as Medicaid patients or Medicare patients on SSI.

Starting in 2014, states have a strong incentive to increase Medicaid eligibility. This will increase Medicaid discharges as a share of hospital discharges, and

based on the Medicare DSH formula, this will increase DSH payments. This is the second box down. My rough estimate is that the change in Medicaid policy alone would increase the Medicare DSH pool from $11 billion to roughly $13 billion in 2014.

The law stipulates that only 25 percent of this $13 billion would be paid under the current DSH formula, so this is roughly $3 billion in expected DSH payments in 2014. The remaining 75 percent, which I expect to be roughly $10 billion, will be divided into two shares: one share would be the $7 to $8 billion range, and that would be used to pay for a portion of hospitals' uncompensated care in 2014; the second share of roughly $2 to $3 billion would be retained as savings for the Medicare Trust Fund.

The bottom line from this chart is that the net effect of this change in Medicare payment policy is expected to be small for the industry on average; in other words, the 2014 payments in the two green boxes will be roughly equal to the $11 billion in DSH payments that they received in 2011. The payments will be redistributed amongst hospitals, but the aggregate level of payments will be similar. However, it is important to note that in future years, if

more individuals gain insurance and uncompensated care costs fall, the payments from the uncompensated care pool of dollars will decline, and the savings to the Medicare Trust Fund will increase.

Now we'll turn to the update. The Chairman's draft recommendation, which I'll show you in a minute, would replace current law for 2014. Under current law, both the inpatient and outpatient updates are set equal to the projected increase in input costs as measured by the hospital market basket minus two adjustments: one is the average multi-factor of productivity over the past years, and the second is a budgetary adjustment of 0.3 percent. Because the updates are effective at different times, the data used in these two updates formulas vary slightly. The bottom line is that, given current projections of inflation and productivity, the October inpatient update under current law would be 1.8 percent, and the January outpatient update for the outpatient department will be 2 percent.

Given the data we presented today and all the various different payment adequacy indicators that Zach, Craig, and I discussed, and given both the outpatient and inpatient considerations that are outlined in your mailing

materials, the Chairman's draft recommendation now reads as follows: The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1-percent update to offset increases in payment rates due to documentation and coding and recover past overpayments. The spending implication for 2013 is that it's expected to decrease spending relative to the update in statute. It is not expected to have any impact on beneficiaries' or providers' willingness or ability to treat patients.

Now just to review the update rationale.

First, the 1-percent update will create some pressure on hospitals to restrain their cost growth.

Second, we need to restore budget neutrality to MS-DRGs. Or, second, we need to adjust for documentation and coding that's needed to recover all the overpayments and restore budget neutrality. But these documentation and coding adjustments should not cause a financial shock to hospitals.

Given the payment adequacy indicators, a 1-percent update is sufficient to preserve payment adequacy for reasonably efficient hospitals, and the difference between current statute and the 1-percent update could be applied to fully recover past overpayments to documentation and coding and prevent further overpayments in 2010.

The 1-percent increase on the outpatient side is appropriate for two reasons.

First, we see strong outpatient volume growth.

Second, we're observing a site-of-service shift toward the hospital outpatient departments from free-standing physician offices. A higher update than 1 percent would only exacerbate this problem.

Now I'll open it up for discussion.

MR. HACKBARTH: Okay. Thank you all.

So we will, as usual, do two rounds, first a round of clarifying questions and then one for broader questions and comments. Peter, do you want to start the clarifying round.

MR. BUTLER: Lucky me. Okay. There's a lot here, and by the way, I think particularly helpful is the looking forward impact of health reform. While it's pretty

complicated, I think you've done a nice job kind of helping us think through what's going to happen. So I have three questions.

The first one, Slide 13. So you make reference here to the HIT payments and you also address them in the chapter and you suggest that they are about $2.5 billion this year and $3 billion next year, and these are one-time payments. So the question, just to get more specific, on a 114 million or whatever it is base, what would the run rate be and the profitability if you did not have the one-time payments in there? So the 5.8 and the 6.0 would be, I think, about -- at least, what, a percentage and a half worse, something like that?

DR. STENSLAND: Yeah. The 2011 number would probably be about one percent lower. The 2013 number would be about two percent lower.

MR. BUTLER: Okay, if you didn't have the HIT payments, which don't continue indefinitely. Okay. That's one.

The second one is on page 16, and you always do a good job at increasingly highlighting that there are efficient hospitals that can live with, and perform in a

quality standpoint. The interesting question I have, and this is a harder one, is that the margins on the inpatient are negative four. The margins on the outpatient are negative 11. It would be real interesting to see if you can find efficient providers on the outpatient side that can actually break even. I would be curious what this distribution would look like for outpatient care because we spent so much time trying to -- you know, the same site kind of issues. It would be kind of interesting to see if there's a really broad in cost structures on outpatient to help us guide, because I think we're fuzzier on why we come up with one percent on the outpatient, frankly, than what we do on the inpatient and we just kind of say, well, there's growth and let's not get too fine-tuned. So that would be an interesting point of analysis, I think.

And finally, on page 20, Slide 20, I just want to understand, then, the recommendation on -- finally, I think the coding offset has worked its way through our pipeline almost out the other end. We've been talking about it for about three or four years and we're down to 0.8, I think, left. But I want to -- so this is what the statute is, 1.8 percent, and CMS had originally proposed a 0.8 offset when

they pulled back on this year.

And so the thinking, then, on the recommendation on the next page, if I've got this right, is that the one percent that would be recommended, really -- you're not recommending an offset on top of that. That is one percent. So you're kind of thinking, well, the statue is 1.8. The 0.8 that is left on the table, you'll net it into this and the recommendation is one percent and no more offsets in effect, right? That's what this says?

DR. STENSLAND: That's correct.

MR. BUTLER: Okay.

MR. HACKBARTH: So this is the format that we've used for our hospital recommendation, is this the third year or the second year? The second year. And for the new Commissioners, the way we arrived at this was two parts. One, we thought it was very important to reiterate the principle that changes in coding systems should be budget neutral and should not be a means by which total revenues are increased. The purpose of coding change is to redistribute a fixed pool of dollars more equitably as opposed to increase the size of the pool. And this is a principle that we have applied for coding change, not just

in hospitals, but in home health and other provider groups that have gone through a coding change. So it's important to recover the overpayments as a result of coding change. So that was one thought that led us to this.

The second, though, was that in view of our overall payment adequacy analysis, including the efficient provider analysis, the negative margins, the whole deal, we wanted to be sure that hospitals got a least a one percent increase at the bottom line in the Medicaid payment rates. And so to bring those two things together in a single recommendation, we said there should be -- they should get that one percent increase and the residual between that amount and the statutory update is credited against the overpayments due to coding change.

So the bottom line, just to emphasize again, Peter, is that there would be a one percent increase in the payment rates for a hospital. So the coding piece is the residual, if you will.

So is that clearer for people? Okay.

Kate, clarifying questions.

DR. BAICKER: I thought the analysis of the efficient hospital distribution was really helpful and

thinking about the types of hospitals that perform well on those outcome measures, I think, would add -- let me start over.

You nicely lay out the characteristics of hospitals with different margins by rural versus urban, teaching versus non-teaching, and show us what the distribution of margins is across those dimensions. Then you focus in on efficient hospitals, which I think is really helpful for us, thinking about what an adequate payment is for good care delivery, and that efficiency is defined by performance along some outcome measures. I would be interested to see how the characteristics of efficient hospitals and how it breaks down along those dimensions where you showed us the margins just to be sure that we are not picking up on only urban hospitals end up as efficient hospitals or only non-teaching hospitals end up as efficient hospitals to see the correlation of those other characteristics to make sure that we are understanding what the drivers of efficiency are versus differential cost structures.

So the question is, do we have that information now, and if not, it would be interesting to see.

DR. STENSLAND: We will give you some more detailed information next time. When we have looked at this in the past, we do have a broad spectrum of them, so you do have some rural, some urban, some teaching, some non-teaching, some safety net hospitals, even, that we've mentioned specifically that we've talked to before, like Denver Health, you know, that kind of a place can be in there.

The thing that is disproportionate in there is larger hospitals, and it is not because they tend to have lower costs due to economies of scale. It is generally because they tend to have lower mortality due to higher volume. But we can give you more detail next time.

DR. NERENZ: My question is also about hospital efficiency, or that concept, and this could relate to either Slide 17 or 18. The definition includes a combination of costs and quality, and that's fine, but I note here that it's relative to other hospitals, so that there's a group, you said it's about 14 percent, that are now in this group identified as efficient. Clearly, in any three-year period of time, you could identify a subset of hospitals as relatively efficient, and I would emphasize the word

"relatively."

My question is, is there a concept, an absolute metric of efficiency that could be tracked over time or that you do, in fact, track over time, so that if in a later three-year period, perhaps 20 percent of hospitals by that metric are efficient, or perhaps now at some future point 50 percent are? I'm just interested. Would any of this analysis or thinking about this change if there was any anchoring to some absolute metric of efficiency?

DR. STENSLAND: Yes, it would change a little bit. I will say that the percentage does change from year to year because what we're saying is you have to be in the top third of all of these things in the three years prior. So in some years, if it was the case that the high-cost hospitals all had low quality, well, then you would have no one in your efficient group.

In terms of having a set number, I think it would be difficult because then we would have to make a judgment call of, okay, what is the acceptable or the desired level of mortality? What's the acceptable desired level of readmissions? What's the acceptable desired level of cost? And then we get into things like people say, well, there's

30 percent waste, and then they'd say, okay, how do you really know it's 30 percent, and it gets very sticky to the point where I would -- I doubt I could do a good job at it. I think I can tell you who's relatively efficient. Telling you who's absolutely efficient, we could try, but I think I would fail.

DR. NERENZ: All right. No, I do appreciate the efficiency, but also at the same time, it would seem that some of our thinking could be influenced if we actually could have the idea that hospitals as a whole group were either moving toward more efficiency or away, and with only using the relative terms, we don't know that.

DR. BAICKER: One really simple pass at that would be, you know, like when we look at obesity measures, you pick the distribution in a given year and then you pick the cut point based on that and then look at the same cut point in future years. You could take a base year, a performance year and say, okay, what's the best third of performers? Take those and then just look at how people perform over time relative to that, not as the only measure, but as another way to gauge --

DR. NERENZ: Yeah, just --

DR. BAICKER: If the whole pool is moving up and getting better, you want to know that.

DR. STENSLAND: And I think one good metric there, we do have mortality. It tends to get better and better and better over time. So on that metric, we would say it looks like things are getting better. The thing where it gets a little more difficult is cost for everybody kind of goes up and up over time, and maybe you could do something with input prices. It would get a little stickier, but I'll see if we can do something.

DR. SAMITT: So my questions are about Slide 4, hospital capacity. So in the advance materials that we read, Figure 1, by my count, there has been a net new add of 70 hospitals in the last five years. And so my question is aimed at not whether there is too little capacity but whether there's too much capacity and whether we've ever really done an analysis of overall hospital bed capacity nationally, essentially. As we try to make a determination of capacity, do we have a targeted number that says we would be concerned about hospital capacity if we achieved a certain level of bed availability nationwide? I think that that would be a critical factor for future adjustments to

help us modulate payment. You know, perhaps, actually, we should be seeing some additional net closures over the coming years as opposed to additional net adds.

DR. STENSLAND: I think the thing that informs at least my thought on that is the occupancy rate, and we tend to see, even adjusting for observation days and swing patient days, a slight decline in occupancy. So if we have a slight decline in occupancy, then there is this question of do you really need more hospitals when you're having a decline in occupancy of the existing ones that are there.

MR. HACKBARTH: Jeff, my recollection is that the occupancy, the national average is, like, 58 percent, and it's sort of fallen slightly from being in the low 60s in recent years. Is that right?

MR. GAUMER: It depends on whether or not you build in things like observation and swing beds, but I would get 60 stuck in your head.

MR. HACKBARTH: Yes.

MR. GAUMER: It's come down maybe a percentage point or two, from, like, 63 --

MR. HACKBARTH: Okay. So let's just stipulate for the sake of discussion that it's 60 on a national average.

My understanding is that there is significant variation around that average across the country. There are some cities where a 90-plus percent occupancy is fairly common and then others, obviously, were much lower. Is that correct?

DR. STENSLAND: That's correct.

MR. HACKBARTH: So as a measure of whether we are approaching efficiency on the aggregate national level, obviously, there's a lot of unused capacity, but it really varies quite a bit.

DR. SAMITT: And just one other quick question. When we measure occupancy, is it versus staffed hospital beds or is it versus staffed and unstaffed, so essentially the capacity to add more staffed beds is needed?

DR. STENSLAND: It's staffed beds.

DR. SAMITT: Staffed.

DR. STENSLAND: So if you looked at certified beds, it would be the lower occupancy.

DR. SAMITT: Thank you.

MR. GEORGE MILLER: Yes, thank you. First, on Slide 6, please, in the reading material, you talked about, if I remember correctly, that 18 percent of all -- excuse

me. Let me rephrase that. That hospitals employ approximately 18 percent of physicians. So my question is, has that driven most of this increase and the shift in the billing, that 18 percent, or is part of that that some physicians in the community are choosing to come and have those services done at the outpatient departments of a hospital? Is that purely driven by the fact the hospitals are now employing more physicians, and I still think the number is around 18 percent.

DR. STENSLAND: It could be driven by both. I think, anecdotally, I think a lot of it is the acquisitions. I think the financial incentives could be driving both.

MR. GEORGE MILLER: Okay. So --

DR. STENSLAND: Like, the financial incentive, if we pay a lot more for an echocardiogram --

MR. GEORGE MILLER: No, I've got the math there.

DR. STENSLAND: Okay.

MR. GEORGE MILLER: But my question is, if a physician, a private physician, chooses to have that procedure done in the hospital outpatient department versus his own office, that is not driven by the choice of the hospital to make that determination, and what percentage of

that number do you think plays into that analysis?

DR. STENSLAND: We don't have -- there's no way to firmly know that number, since hospitals don't report that data. I think the anecdotal information would be a lot of it, especially the cardiology stuff, is the acquisition of practices.

MR. GEORGE MILLER: Okay. Okay. But still, at least my numbers, or reading, it's still only about 18 percent of the hospitals are employing physicians at this point, correct?

DR. STENSLAND: I think a lot -- maybe it was that 18 percent of physicians are employed by hospitals? A lot more than 18 percent of hospitals are employing physicians. There's a lot of hospitals that have physician employees.

MR. GEORGE MILLER: All right. Slide 18, please. Again, the question about the efficient hospital and the numbers that we have there. So if the median is two percent, that still could mean maybe 40 percent of the efficient hospitals have negative margins on Medicare. And if we follow Peter's question, it would be interested to see, even breaking that down to the outpatient side, what percentage of those hospitals have negative margins even on

the outpatient side, as well. So you could be an efficient hospital and meet your definition and still have negative margins on both the inpatient and outpatient side, about 40 percent of the hospitals.

DR. STENSLAND: Correct.

MR. GEORGE MILLER: So if that were true, would we have a different recommendation to dealing with this, if the numbers continue to be negative?

MR. HACKBARTH: No.

MR. GEORGE MILLER: No?

MR. HACKBARTH: Your point is correct --

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: -- that this is an average or a median for the group --

MR. GEORGE MILLER: Median.

MR. HACKBARTH: -- and that implies that there are some efficient hospitals that have negative margins. That's true. The recommendation was formulated with that understanding --

MR. GEORGE MILLER: With that knowledge?

MR. HACKBARTH: With that knowledge.

MR. GEORGE MILLER: Yeah.

DR. MARK MILLER: And the definition of efficient provider, so that it's not driven entirely by cost, was a quality and cost concept --

MR. GEORGE MILLER: I saw that, yeah.

DR. MARK MILLER: -- and that's why that could -- that also can occur.

MR. GEORGE MILLER: Yeah. All right.

DR. MARK MILLER: [Off microphone.] The definition itself --

MR. GEORGE MILLER: And then, finally, on the DSH payments, I guess that's Slide 19, and I guess I'm unclear on what we think the expectations of the total cut would be in the future, particularly with States either choosing to opt in or opt out of the program. So we just don't know for the future -- well, what impact would that have on payments? I think you said earlier that it would be about $2 or $3 billion. What percentage of that --

DR. STENSLAND: Are you --

MR. GEORGE MILLER: -- on total payments?

DR. STENSLAND: Are you saying if the State opts in or opts out?

MR. GEORGE MILLER: Well, I made two, I'm sorry,

two statements. One, the first statement. But my question is, what impact is this going to have on total payments, these DSH cuts that we proposed here?

DR. STENSLAND: Okay. So the way we did this is let's look at the expectations of a share of the States will implement this, and we're using the CBO numbers, which I think are reasonable, and they made these estimates after the Supreme Court case --

MR. GEORGE MILLER: Right.

DR. STENSLAND: -- and this is about 25 percent. There's going to be something on the, I think, order of a 20 percent increase in the Medicaid rolls and a 25 percent reduction in uninsurance. That's their best estimate. And if we take those estimates and then model them, you end up saying that, well, in 2011, you used to get $11 billion in DSH payments, and then if you just model these policy changes, you'd end up with $3 billion in DSH payments and about $7 or $8 billion in uncompensated care payments and maybe things would only go down, net aggregate payments going out to the hospitals, maybe by a half-a-billion dollars.

So in 2014, at least, the amount of money coming

out of the Medicare Trust Fund going out to hospitals for either DSH or uncompensated care probably won't be that much different than it was in 2011.

Now, going forward, if the exchanges take off and your rate of uninsurance goes down, then the rate of uncompensated care payments will go down and this number will go down.

In terms of what -- it does make big distributional effects whether you join or don't join the -- whether the State decides to expand Medicaid eligibility, and I'm not saying whether that's a good thing or a bad thing, but there's kind of four things that would happen. First, if you do -- if you choose to expand Medicaid eligibility, then you get -- of course, you get those Medicaid dollars. If you don't, well, then those people might be uncompensated care. They might not pay their bills. And then you would get some of the uncompensated care pool, like maybe 20 or 30 cents on the dollar.

The next thing that happens is if your State did not expand Medicaid eligibility, well, then your number of Medicaid people wouldn't expand, so you would get actually a little bit smaller DSH dollars than you would have

otherwise. You might -- and then your Medicare payments might go down by three-tenths of a percent or so because you didn't have the expansion in the Medicaid.

And then the other thing that happens is if people don't expand their Medicaid rolls, then that whole pool gets smaller and then everybody in the country has a little bit less uncompensated care dollars to spread amongst themselves.

I hope that wasn't too much in the weeds.

MR. GEORGE MILLER: If my State, for example, did not choose to expand Medicare -- Medicaid, I'm sorry --

MR. HACKBARTH: So you'll be worse off --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- as a result of that decision.

MR. GEORGE MILLER: Exactly.

MR. HACKBARTH: Right.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: So can I go back to the beginning of what you just said, Jeff? Do the uncompensated care payments in the bottom left box, do they come out of the Medicare Trust Fund?

DR. STENSLAND: Yeah.

MR. HACKBARTH: Okay. The way I had initially interpreted this graph was that the savings to the Trust Fund came because the uncompensated care dollars were not coming out of the Medicare Trust Fund, they were coming from general revenues or some other place. So I misinterpreted it. So --

DR. STENSLAND: Yeah. I think what I mean by savings is just not that full $10 billion pool --

MR. HACKBARTH: Yeah.

DR. STENSLAND: -- will be going to the hospitals. Part of it will stay in the Trust Fund, and how much stays in the Trust Fund and how much goes to the hospitals all depends on the rate of uninsurance.

MR. HACKBARTH: Yeah. Okay.

MR. GEORGE MILLER: So the combination of these two, the policy recommendation of the one percent plus lower DSH payments has --

DR. MARK MILLER: Well, I think on net, what the analysis is saying is with the best set of assumptions, the DSH, quote-unquote, payments, which are now DSH and uncompensated care, remain about the same. They were $11 billion in 2011 and then $11 billion at 2014. It's

shuffling money around. But where you could feel it is in the ways that you just said, what your State chooses to do about Medicaid, and if you're a hospital who gets a bunch of DSH but doesn't do a lot of uncompensated care, then the formula will reallocate the same dollar amount, but across hospitals differently.

MR. GEORGE MILLER: Right. Right.

MR. HACKBARTH: And from the standpoint of --

MR. GEORGE MILLER: It still means less money.

DR. MARK MILLER: No.

MR. GEORGE MILLER: No? All right --

DR. MARK MILLER: The first blush is that there might be a small decrease. I think the exchange between you and Jeff is he was saying about a half-a-million. But, I mean, I think what I found very helpful about this analysis, and I'm glad Peter mentioned it, too, this has been kind of a black box for me, and as he walks through it, all the puts and takes, at least using the current assumptions, is on net, there's not a big change in terms of total dollars, but it will redistribute the dollars.

MR. GEORGE MILLER: I guess that's the point I'm making --

DR. MARK MILLER: Well, yes. For any given hospital, it could be a change.

MR. HACKBARTH: And if you're in a State that opts out of the Medicaid exchange --

MR. GEORGE MILLER: That's the point.

MR. HACKBARTH: But from the standpoint of Federal policy --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- you know, the Federal Government, they said, we'll pay 100 percent of those costs for a period of time and then it falls down to 90. So from a Federal perspective, we've offered a pretty attractive deal to Oklahoma. If they still choose not to do it, that's their call.

MR. GEORGE MILLER: Yeah. Yeah. Both issues. Okay. Thank you.

DR. HALL: Thank you for this analysis. I wanted to go back to 16, the standardized costs, if we could put that up again. So that looks to me like an almost perfectly random distribution, all right, a Gaussian distribution, which you might predict if there was really not much in the way of difference in the population. You've controlled for

a lot of variables and you got exactly what you would predict you would do if you did all the rigid controls.

So what I'm wondering -- and since to get into the good group, you either had to have lower mortality or lower costs, right, if I've got that right, but not necessarily both. Am I still okay?

DR. STENSLAND: You have to do -- in the top third on one and you can't be on the bottom third in anything.

DR. HALL: Understand. But if you look at the first two criteria, so I could stay in that criteria if I had lower costs, but my mortality wouldn't necessarily have to be in the best group, is that right? So if that's correct, then can we really say that taking a third of these are the most relatively most efficient hospitals? I think, to me, that term might be misinterpreted. Maybe I just don't understand these statistics enough to --

DR. MARK MILLER: First off, it's not a third. It's 15 percent of the hospitals. What was the third you just referred to?

DR. HALL: The third criteria was you couldn't be in a bad group in any one of the three years.

DR. MARK MILLER: I see --

DR. HALL: The third criteria. So I'm wondering what it is we're looking at other than random distribution. And that may be valuable, but I don't think we should call those relatively efficient.

DR. STENSLAND: The general idea here that we're trying to get at is who has good quality and average or better costs, or who has average quality and does well or better -- or okay or better on costs. So it's kind of saying, if you're good on costs and you are average on quality, that's still above average. If you're good on quality and average on costs, well, that's still above average and will still put you in this above-average group either way.

DR. HALL: Right. So as long as you have all the data, wouldn't it be fun to see if there are some real home runs here and say, what about hospitals that have lower costs and lower mortality for some combination of time in the three years? Then I think we might have a real gold mine here. But otherwise, I think we're looking at random variation.

DR. STENSLAND: That number is really small. Like, if you said -- if you look at who does --

DR. HALL: That's what I thought.

DR. STENSLAND: -- who does really well on the top third on mortality, readmissions, and cost in every year for three straight years, basically meaning you can't have -- that also means, basically, you can't have any sort of really negative random event in any of those years, you're probably down to about a dozen or so hospitals.

DR. HALL: Okay. Thank you.

DR. NAYLOR: So this was really an exceptional report. I would love to pursue the occupancy rate -- it's not on any of the slides, but the decline in occupancy rate -- and try to, if we could, uncover -- 58 percent or 60 percent, what does that mean? And when you're calculating margins, Medicare payments minus cost divided by margins, how does infrastructure that is sitting there but needs to be paid for come into the calculation of those margins? That would be -- I mean, I really think that's very important.

The second piece is in the document itself on page 11, you refer to post-acute services is the one area in this bucket where services have actually declined more than 1 percent. Could you tell or in the future describe what that

means? Because if we're seeing hospitals shift both to outpatient and also decline in what might have been traditional post-acute services that they provided, does that have implications for the other sectors that we're looking at mandates?

Thanks.

DR. MARK MILLER: Do you want to take a [off microphone]?

MR. LISK: We can take a look at that. A lot of decline in post-acute-care facilities are the ones that had actually, if you recall in the past, really negative margins on some of those, and a lot of those are the people who've gotten out, who found that they're basically -- probably their direct costs on those are -- you know, they're not covering in their direct costs, so they get out of the business and use that space for something else in some cases. So that may be why you see the decline on the post-acute-care side, for instance, going on. But we can get you some other numbers on that if you're interested.

DR. MARK MILLER: I mean, another way you might think about it -- and this has come up implicitly in some of our conversations -- if a free-standing approach to -- or

non-hospital, however you want to think about it, to delivering the post-acute care -- home health or whatever the case may be -- turns out to be a more efficient model, then it may be that as a natural function in the market you start to see that moving out. And what Craig was saying, when we look at the post-acute-care services in the hospital, they can appear -- they can be negative when you include all of the costs, but he was referring to the direct margin. It can often be positive in the direct margin and actually contribute to the bottom line of the hospital overall. Part of the reason we look at the overall margin is -- and George has made this point in meetings -- you know, the hospital CFO, CEO, tends to look at the operations across all the lines of business, and some may be helping you with your fixed costs, some may be highly profitable, some not so much, you know, that type of thing.

DR. NAYLOR: I don't know if you want to answer then. On those hospitals that have a 60-percent occupancy, that's to the former question, how does that influence the numerator here in calculating the margins? So how much of that are those fixed costs?

MR. LISK: I mean, the fixed costs have to be

distributed somewhere in terms of how they're done. So a hospital that has a lower occupancy may have a higher share of fixed costs in terms of capital per unit of service. So they're going to have -- on average, they should have higher -- they likely have higher fixed costs, and that's one of the reasons why they have on average lower margins, particularly when we get into -- it's hard because hospitals are multi-function facilities that have lots of service lines. It's easier when you see -- when we get down to talking about rehab hospitals tomorrow, is when you have -- when you're more focused, the larger size of the unit, they have much higher margins, and you see a much bigger relationship there. And so if you don't -- both sides in occupancy make a difference in terms of the underlying costs of those facilities.

DR. MARK MILLER: To draw a linkage with Craig's comment -- and, Craig, if this is not where you were saying, you should comment. But in some ways, so you could look at that as, well, I'm a low-occupancy hospital, I have high -- you know, I'm not covering any fixed costs. And then on these charts they're going to look like they're not doing well, and it could feed into your decision that says, well,

we should pay more. I think Craig's point was, well, wait a minute -- and, again, I don't want to put words in your mouth -- if that hospital is in a town in which there are many other hospitals and they have higher occupancy rates, is that a good decision point for making a payment decision? If I missed --

MR. LISK: No, that's accurate. That's what I --

DR. NAYLOR: And that would be my point as well.

DR. HOADLEY: Yeah, I just have two questions. One goes back to the DSH discussion on Slide 19. When you talk about the fact that hospitals will vary in how they get the dollars on that bottom green box, I mean, it really should -- if the formula is set right, it should come down to the fact that a particular hospital is converting what used to be uninsured patients to Medicaid insured or exchange insured patients, you know, they're not going to need these payments as much versus the ones that are still taking care of the people who remain uninsured. Isn't that really the split we're talking about?

DR. STENSLAND: That's generally the split. The only other twist in there is the uncompensated care isn't just charity care; it's also bad debts.

DR. HOADLEY: Okay.

DR. STENSLAND: So a portion of that money will be going to hospitals that really don't do much charity care. They just have people maybe with high-deductible plans who aren't paying their deductible.

DR. HOADLEY: Okay. That's helpful.

And my other question is on the documentation and coding changes. I was unclear from the reading materials. It seemed like one place had said that CMS did not have any authority on its own to recoup these additional costs, and someplace else it said they were looking at maybe doing this in 2014. So, you know, what is the status? In other words -- because if they do have the authority, then they can get to this bottom line of our recommendation without Congress intervening, I would think.

DR. STENSLAND: There's two aspects of it, and one they have authority over and another one they don't.

DR. HOADLEY: Okay.

DR. STENSLAND: One is they can affect payments going forward, so they could say in 2014 we're taking a six-tenth or an eight-tenth or whatever they decide the amount is necessary to prevent overpayments going forward, they can

do that. But then there was these overpayments that have been accumulating from 2010 to 2013, and they need some new statutory authority to do that.

DR. HOADLEY: Okay.

MR. ARMSTRONG: Could you go to Slide 6, please? I want to make sure I understood the final bullet. There are two parts to that sentence. One refers to a $1.5 billion change, and another is a $200 million change. Could you just kind of walk through that for me?

DR. STENSLAND: Okay. So what we're looking at here is what did the hospitals get because they were being paid hospital rates for these two services, E&M visit and echocardiograms, and what would they have gotten if they were paid physician office rates. And in 2010, the difference was $1.3 billion, and that difference in 2011 grew to $1.5 billion, and the sole purpose -- the sole reason or the main reason it grew was simply because there was this site shift, where they started doing more stuff in the higher-paid setting and less stuff in the lower-paid setting.

MR. ARMSTRONG: Got it. So for the hospital outpatient services, we're seeing a huge increase in

volumes. You said a 5-percent increase per year. It's being driven by a combination of things, but this is a big part of that explanation. This is costing us a billion and a half more per year for having purchased the same services in a different site, and yet they're losing 11-percent margin on this business? There must be some good reason that they're doing this.

DR. STENSLAND: Well, part of it could be they're going to have this service line, and they know if we have this service line and we get all the echocardiograms from all the cardiologists' patients, we're not just going to get Medicare echocardiograms, we're also going to get echocardiograms from you and maybe you'll pay us more, too, that's part of it. I think another part of it you could say that they're going to have this business and they want to cover more of their fixed costs by growing their volume, that could be part of it, too.

MR. LISK: Just think about this, when we get back to the direct costs, okay? So let's say they're losing 10 percent, but they're not losing 10 percent on that marginal case. That marginal case is contributing, really, to their -- each additional case they take in is covering some to

their bottom line. So let's say they have -- they really probably have a 20 percent -- if it's 20 percent or 30 percent direct cost margin, so they're covering their fixed costs -- I mean, they're covering their variable costs for that individual case, and at the same time helping cover some of the fixed costs and overhead costs of the facility.

MR. ARMSTRONG: Yeah, so we're in the business here of setting rates on a per unit of service basis, and what we're seeing is behavior on the part of hospitals that is rational, I assume, which is to take on more and more volume, and yet they're losing 10-plus percent on every one of those cases, according to our analysis. Setting rates is not having much of an impact on those behaviors. So I just wanted to make sure I was reading that right. I mean, it implies that there is some overwhelming reason beyond the reported losses that they are continuing to bring in these extra volumes, and I just wanted to clarify.

MR. HACKBARTH: I don't think we should kid ourselves that by manipulating the price paid per unit of service, that we're ever going to use that as the mechanism to get to the right volume and mix of services. If we want to improve, alter the volume and mix of services, in my

view, you need to move away from fee-for-service payment, not continue to tweak endlessly the unit prices.

MR. ARMSTRONG: Agreed. I think the other way I was thinking about this is that you could make the argument that we're overpaying by $1.5 billion for these services. Or you could make the argument we're underpaying by 11 percent. And that's -- I'm just trying to wrestle -- I want to be clear. First of all, the data would lead you to either one of those conclusions, and that's I think what I'm trying to struggle with.

DR. REDBERG: So staying on Slide 6, I'm just interested in the absolute numbers. Can you give us an idea of how many outpatient E&M visits and outpatient echos there were in 2011 and how many in physician offices?

DR. STENSLAND: We have those for you, but maybe I'll e-mail you those just to give you the right number.

DR. REDBERG: Okay. That was so quick. So go to Slide 18, the efficiency slide that we've talked about a bit already. But I'm also interested in the patient satisfaction because there has been data published in the Archives of Internal Medicine about a year ago suggesting because of the highly technical and specialized nature of

health care, it's very hard for patients to really judge quality of care. Patient satisfaction, in fact, was linked to increased mortality and suggesting it correlated more with volume of services perhaps. But looking at this, what I can get from this in share of patients rating the hospital highly is they seem to be equal in hospitals where they had, you know, a 13-percent lower chance of dying or a 3-percent higher chance of dying. And the same with costs, if they were in a high-cost or a low-cost hospital, patient satisfaction seemed about similar, which just makes me wonder. I don't think patients are in the best position to really judge quality of care. If I was a patient, I would notice more, you know, how quickly I was seen, how good the food was, whether the nurses were responsive. And while that's important, it's probably not related to what we're looking at in terms of quality and cost of care. Is that a reasonable assumption?

DR. STENSLAND: Well, I think you're probably not alone in that thought.

DR. MARK MILLER: [off microphone].

[Laughter.]

DR. STENSLAND: When you look at the data, first,

there really isn't much of a correlation with the mortality, and I think part of that is you're only surveying people who are alive at the end. So you have a little bit of a censored sample here.

[Laughter.]

DR. REDBERG: [off microphone] are not filling out the surveys.

DR. STENSLAND: They're not filling out the survey. The other thing you are doing, though, is you are looking at people who were readmitted, and you do see a strong correlation between readmission rates and patient satisfaction, probably stronger than you do on any of the process measures in readmission rates.

So, you know, it's not perfect, but it isn't completely unrelated, I don't think, to all the quality measures, at least. Probably a strong relation with the readmissions at least than anything else, I think.

DR. MARK MILLER: And just to defend Jeff a little bit here, he's also thought -- I believe this is correct, Jeff. It's pretty interesting that year over year, each time you do this, it does edge out for the efficient hospital, that however good a patient is at judging -- and

we're aware of all of that -- he thinks it's interesting that it does kind of edge out year after year, and over time he's kind of brought me around a little bit.

MR. HACKBARTH: Okay. Let me just be the Time Scrooge for a second. We're well behind schedule. I'll leave it at that. This is a very important discussion, so I want to get through not just this round but also round two, which is your opportunity to tell me whether you like the recommendation or not, and if not, what you would change in it. And so I ask your help to get through both the end of this round and the next round as quickly as we can.

DR. COOMBS: So I have a question about the whole -- what would be Figure 2 and 3 in the reading, just about how the observational status of patients coming into the hospital impact. I think you alluded to it in one of the sentences, how it impacts both of those slides in terms of the number of discharges.

MR. GAUMER: Jeff, maybe Slide 5, that one up there?

So what we said in the mailing material as well as in this slide here is that one of the reasons we think that inpatient volume is declining is that there's an offsetting

increase in outpatient observation cases.

DR. COOMBS: Right.

MR. GAUMER: So what used to be the short inpatient stay is becoming an outpatient OB. And that's something we see growing significantly, something like 64-percent growth in the last eight years, or something like that, I think we say in the mailing material. It's something that we're tracking on and trying to understand a little bit better.

DR. COOMBS: So my question is: Can you quantitate the impact of the observation status?

MR. GAUMER: It's hard to do a one-to-one kind of comparison of this many missing inpatient stays results in this many outpatient observations. There's not exactly a one-to-one relationship because you've got beneficiary increase occurring and you've got ASCs in the mix. So we do what we can to try and quantify that. But not right now. We can look into it.

DR. COOMBS: Thanks.

DR. STENSLAND: The one thing to remember is it's not a full offset because occupancy, even after adjusting for observation, is still going down.

DR. COOMBS: Right. And then on Slide 18, I'm just very curious about the relatively efficient hospitals compared to the other group. What percentage of for-profit hospitals -- did you have a chance to look at that -- are in each of the categories?

DR. STENSLAND: I don't think it's that different, but I'll get back to you.

DR. COOMBS: Okay. Thank you.

DR. DEAN: To follow up on Bill's question about whether that could be a random variation, I think the answer to that would be how consistent is that group, and if you had the same hospitals in the efficient group year after year, that would say this is not a random thing. Do you have any data about that?

DR. STENSLAND: It is pretty consistent from year to year, but the way I'm designing it is trying to avoid the random variation. If you look at all -- almost all the other stuff you see out there in U.S. News & World Report and everything else, they take a snapshot, and they say, okay, who had low costs this year and had low mortality this year? And it's a snapshot of that one year.

The way we do it is we say, well, who was good in

the prior three years? And then we say, okay, now we'll get the group, and we'll look at their performance in the next year. So this next year unless -- it shouldn't just be a one-year random variation, shouldn't affect those averages in that other year because we're taking -- or getting our set from a different set of years. Our measurement year is different from the years that we used to get our set of efficient providers.

DR. MARK MILLER: And to get into it, you have to be consistently over those three years, which also flattens out some of that.

DR. DEAN: Is there any extension even beyond the three years? Maybe three years is enough, I don't know. But the longer you go, the less it becomes a random issue.

DR. STENSLAND: Yeah, I'll get back to you with the consistency.

MR. HACKBARTH: That's the other thing that happens, though. The longer you go, you know, institutions change leadership and they become more efficient or less efficient. So in some sense, the longer you go, you're maybe not dealing with the same institution in some way. So there's a tradeoff to be --

DR. DEAN: But hopefully the longer you go, the more you could learn about what are the characteristics of those institutions that can stay in these -- can meet these parameters over a period of time, I guess, I think, because that's what we're trying to get to. What is it that makes these hospitals different?

MR. HACKBARTH: Cori, clarifying questions?

MS. UCCELLO: So I just want to quickly kind of reiterate Craig's interest in understanding a little bit more about the closures and entrants and finding out whether these are based on population needs or payment or management policies or anything like that. And so I'm wondering if another metric that we can use, aside from the occupancy, is also just a beds per thousand type of metric.

MR. GAUMER: That's something that we did report to you all last year, and I can't remember who initially suggested we do that, but we started looking at bed capacity on a per capita basis. We did it again this year, but we didn't put it in the mailing material or the slides because it seemed relatively flat or kind of a non-finding. Not a great enough change to bring to your attention, we didn't think, but we'll continue to look at that.

DR. STENSLAND: And I just want to say quickly, that might not be what you want to look at, at least when we were thinking about it, because what happens if a system actually improves like we want it to improve and things start being done, people get healthier, we got things done at a lower cost setting, we have less need for hospital beds? We might end up seeing more decline in the number of beds per thousand. We don't want to say, oh, no, we don't have enough hospital beds, because we have a decline in the number of beds per thousand, because that might be exactly what we want, especially if we see a decline in the number of hospital beds per thousand, which we might a little bit, but we also see even a further decline in occupancy. Then we would say, well, do we really mind that we have fewer hospital beds per thousand if we actually have lower occupancy.

MS. UCCELLO: That's a good point. Thank you.

And regarding observation stays, I seem to recall in the past couple of years we had some long discussion about observation stays and concerns about the increase in them, but I can't remember -- and I didn't have time to look any of this up. A lot of it was in the context of SNF

eligibility, I think, but can somebody remind me if there was anything else that we were thinking about or looking at there?

MR. GAUMER: We did this back in, I guess it was, October of 2011, so it might have been your first year on. I can't recall. But we looked at observation because we saw this jump on the outpatient side, and the context was what is this and how do we explain it and what do we do with the information. And we posed the question to the Commission where to go with this, and I think that the Commission was somewhat mixed on whether or not this was a problem or not a problem or some kind of positive trend. And we started going down the road of is this something that is a concern related to the three-day SNF prior hospitalization policy. And I think generally short inpatient stays came into the mix, too, and we have kind of continued to monitor, but this is something that I think that, you know, the Commission hasn't pushed to the forefront of the agenda recently.

DR. DEAN: I can tell you that at least in one setting it's purely the RAC process that has driven it. I mean, in our case, short stays are what the RAC reviewers are looking at, and so you want to reduce those. And so we

use observation way more than we used to for that one single reason.

DR. MARK MILLER: And that came out in the analysis that we talked about here as one of the reasons. We've had a little -- there's a lot of bandwidth issues here of what we can do. We've had a couple of internal conversations about coming back to this amidst a pile of other things that we have to do. We'll take another look.

MR. KUHN: Go to Slide 13, please. Just a quick question about the file dot point there, the one on HIT payments will also have differences between payment updates and cost growth. Are you making -- is the point there is that a dollar-for-dollar tradeoff? And what are the costs? I guess when you look at the HIT payments that are coming in right now, I think most folks in the hospital community will tell you that the systems they're buying are much more expensive than what they are -- the payments that are coming into the system. So I'm trying to understand exactly what are the additional costs that we're talking about here.

DR. STENSLAND: Well, the additional costs are going to be in our cost growth figures, so like when you look at our cost growth figure of 2.7 percent in 2011,

that's going to include whatever the IT costs were. And when we look out at our costs and look at what is the cost growth this year in 2012, the information we get from other sources, that's all in there. And so this idea that the cost growth is going to be bigger than the update is partly because of the IT costs that are in that cost growth.

On the other side, then the payments are going to include these HIT payments, and that's kind of where the offset is coming from.

MR. KUHN: Okay. That's helpful. And so within that cumulation of the cost growth, are you seeing the HIT payments from the data that you're getting are -- the costs are greater than the payments just on the HIT side alone?

DR. STENSLAND: We don't get enough data to know the marginal difference in your HIT costs due to meeting meaningful use versus the HIT payments. So all we get in the information from the publicly traded companies who publicly report this, and they generally say that their HIT payments are much bigger than their HIT costs, their marginal costs for becoming meaningful users. But, you know, they're talking to their stockholders and trying to convince their stockholders they're good at making money.

So I'm not sure if that's the only source you want to look at.

MR. KUHN: Thank you.

MR. HACKBARTH: [off microphone] Round 2. As I said, please [off microphone].

MR. BUTLER: Four quick points. One, in the beginning, you noted per capita spending for this sector at two percent. That's pretty darn good. When you accommodate price increases and volume, if you said four years ago we could have two percent -- and this is about a third of the Medicare budget, I think, so it's not bad, and helping keep well below IPAB-kind of triggers. So this is an important decision. This is, like, a third of all the spending these recommendations affect. So it's a big deal.

Second, on beds, just a quick comment on this. Craig raised it. You have got 18 hospitals opening, eight closing, a net increase of 1,100 beds in the country. That's not much. That's not really, in effect, any change. But the real question is, without much change, do we have excess capacity? My own opinion, we do, and it's mostly in urban areas with some freestanding underperforming hospitals where there's others that are accessible and you've got to

close a whole hospital, not just decrease number of beds to make a difference. We've talked about even having outcome measures for conditions of participation and other things to kind of highlight, maybe, what shouldn't really shouldn't be in the system going forward.

Third point, George brings up kind of shifts in dollars, that not everybody will be treated equally even though it looks like the DSH payments and the uncompensated care is somewhat of a wash. We just need to keep our eyes on that. Those that have a high percentage of Medicaid and SSI days get a lot of DSH payments. If they have low charity care, they're not going to come out whole and so there'll be big shifts of dollars for some. Even if you're a really big Medicaid provider, you may come out on the short end. Equally, the public hospitals that have a ton of uncompensated care that you think is going to get funded, a lot of people will say they're going to get their Medicaid card now and go elsewhere. So there could be unintended consequences that we'll just have to watch.

Finally, to the recommendations, I understand the rationale for the inpatient one percent and I think that's probably where we'll end, or thereabouts. I'm less clear

about the outpatient. I need to get in my own mind the rationale for one versus something a little bit different. So I'm not quite there on the outpatient, but the inpatient is okay.

DR. BAICKER: The framework seems really reasonable to me, and I would also applaud the emphasis on maintaining the budget neutrality of the coding updates, that we want to be able to do those kinds of amendments to realign payments across the spectrum without necessarily building in change in the level. So I urge us to continue with that.

DR. NERENZ: Just a quick comment on the slide that we have showing here, 21. The recovery to passover payments is highlighted, if I could call it that, as part of the rationale for the one percent, and I am thinking also about Peter's comment earlier about through the python, was it exactly. For those of us who are sort of new to this, I'm wondering if, either now or at the remaining discussion of this, we could talk about what exactly this metaphor of through the python looks like. Are we truly at the end of this concept? Have these overpayments been recovered? Are they still being recovered? Is this going to continue

infinitely into the future? Just a little more on that would be helpful.

DR. MARK MILLER: All right. Here's the quick answer, and Jeff, keep track of this. The quick answer is they continue, and they can be stopped by taking a portion of this and saying, okay, here's a permanent adjustment to stop the ongoing overpayment. So let's say that happened tomorrow. There's still an $11 billion, between 2010 and 2012, if I remember my numbers right, that has not been recovered, and the agency statutorily doesn't have the authority to go get it.

So both things are true. There's a block that are unrecovered and is still going on. Action could be taken to stop that. Let's pretend that happened. You'd still have a block.

MR. HACKBARTH: [Off microphone.]

DR. NERENZ: [Off microphone.]

MR. HACKBARTH: Yeah.

DR. MARK MILLER: Most has been recovered? Jeff?

DR. STENSLAND: I don't think most. There's two things. There is getting the rates back down so we're not overpaying going forward, and most of that has been done.

The other thing is recovering past overpayments. Most of that probably hasn't been done. We've recovered the 2008 and 2009 overpayments. We haven't recovered 2010, 2011, 2012, 2013.

DR. SAMITT: So what I like about the recommendation is that it's a sound methodology for coming to the appropriate pricing change. What I'm not comfortable with is really in the bigger picture of the concern about even overcapacity and our desire to move the system to a more value-based approach. You know, I'll stay silent on that for now, based mostly on your comments, Glenn, that we're not going to influence a rebalancing of services by tweaking these small percentages of fee-for-service.

What I'd rather do is the Commission in the future really should focus on recommendations, bigger recommendations that address pricing that shifts true physician services to physician settings and shifts true ambulatory surgery services to ambulatory surgery centers and even considers the notion, to Peter's point, about whether we have alternative reimbursement methodologies with reductions to hospitals that have low occupancies in settings where the market-based capacity is in excess or

sufficient. While it may not be fair, the reality is that we do want to influence the closure of hospitals that have significant underutilization or overcapacity when there is ample access for Medicare beneficiaries to other facilities in that market.

MR. GEORGE MILLER: First, I'd like to deal with the -- the coding issue has been discussed. What I'm not clear about, while I understand the numbers not being collected, I'm not clear that over the period of time when we started the repayment, that patient acuity has not changed, patients aren't sicker or staying longer. It seems that we're just talking about the repayment and not addressing that if there is appropriate documentation now -- the 2007 study -- excuse me -- DRG system was said to be flawed, said to be not appropriate, so we came up with the, or they came up with the MS-DRG system.

It would seem during that time, while I understand the overpayment the first couple of years, it seems that as it has gone through the pipeline that we are now recognizing that patients have improved. So where that number is, I don't know, but I at least wanted to address that problem. Have we addressed and looked at, has acuity changed over the

last four years? Are patients sicker? Are they staying longer? We've seen a lot of information about obesity, diabetes, and other chronic care diseases, and is that reflected now in what we're paying for? That's a --

DR. MARK MILLER: This is -- you know, we went through this in gruesome detail when we first brought this issue up, and given the time, I won't grind us through all of it --

MR. GEORGE MILLER: Sure. No.

DR. MARK MILLER: -- but what I will say is this, Jeff --

MR. GEORGE MILLER: George.

DR. MARK MILLER: No, I'm now speaking --

[Laughter.]

DR. MARK MILLER: I'm sorry about that. George, I definitely know who you are.

[Laughter.]

DR. MARK MILLER: I want to just make sure I don't say anything stupid, which is why I'm going back over to --

MR. GEORGE MILLER: To Jeff. I got you.

DR. MARK MILLER: -- to my staff.

MR. GEORGE MILLER: He's the one down there.

DR. MARK MILLER: Exactly.

[Laughter.]

DR. MARK MILLER: Jeff, the way I would answer this question is in making any of our estimates, we are adjusting and taking into account the changing case mix.

DR. STENSLAND: Right.

MR. GEORGE MILLER: Yes. Okay. I am also -- while I respect what the other Commissioners are saying and understand, philosophically, if we look at the big picture, I understand bed capacity and those issues. But as we go through some of the other silos that we talked about, we see where there may be other drivers for ASCs doing business, as I mentioned earlier, and they don't seem to provide the same level of care to all patients in the Medicare population. So I'm a little bit concerned, especially about safety net hospitals in larger communities where certain patients don't have the option to go to some of the other hospitals.

And then we had a statement where some patients in New York, I think the reference was, they chose to go to a different hospital and bypass other hospitals because they felt they got better care, not necessarily documented better care, but they felt that way.

So it's not a simple picture as we describe, but it is complex. Health care is a diverse, complex entity in the United States and sometimes we frame things in terms of, like there's one hospital that has all of these things and we can make one decision influence it, it's a diverse nation that has different components. So I want to make sure we're very careful about that.

I'm with Peter. I understand the update and think I can support on the inpatient the one percent. I'm very much struggling on the outpatient update, particularly with the negative margins. Again, it's not just one hospital, so we've got some that have more than 11, some that are making money, and if we're trying to effect a permanent change, it's just the right recommendation dealing with all the complexities that we have, so I've got to think about the outpatient one.

DR. HALL: I think this was a terrific piece of work and I learned an enormous amount from this and appreciate it. And like any good report, it raises as many questions as it answers, but in terms of our direct task today, I'm in favor of the draft recommendations.

DR. NAYLOR: So I'm, in general, in favor. I do

really support Greg's comments about the opportunity here to look at -- and I really like the analysis around the efficient provider, and so I like the opportunity to really look at a national average of 60 percent bed occupancy and what that might help us to understand in terms of opportunities to get to an efficient overall system.

In terms of the inpatient-outpatient recommendation, I also wonder about, but not, unlike George, whether or not we might think about how financial pressures on the outpatient system could create a more efficient system for us, as well. So I am not sure that -- if one percent is where I would land. Maybe less.

DR. HOADLEY: Yeah, I'm generally in favor of where we've landed, and I agree it's been some really good work to get us here.

Two small comments. One is we should be very clear in the text around this of this distinction on the coding and the documentation, you know, this business, the difference between the going forward and the recovery. I think it's clear to me now, but it wasn't when we started this.

Also, given what we said at the very beginning in

terms of the spending implications, the statement here is ending relative to statutory updates. If we were making the comparison to the sequester baseline, we're actually adding spending on each sector, I think. Is that -- do I understand that correctly?

MR. HACKBARTH: Not necessarily on each sector, but in this case, we would be --

DR. HOADLEY: I mean, each of these hospital --

MR. HACKBARTH: When we get to January, we will have more to say about the likely spending relevant to the current law baseline, and so there will be more detail on that issue in January.

DR. MARK MILLER: Yes, that's true. And the only thing I would say here is keep in mind, if you just focus on the update, yes, it seems like it's higher than the sequester. But then you have the DCI effect. That may still mean that we're at or above the sequester --

DR. HOADLEY: Okay.

DR. MARK MILLER: -- but that piece would have to be separately thought about.

MR. HACKBARTH: Scott.

MR. ARMSTRONG: I, too, generally think a one

percent adjustment is where we're headed and makes sense to me. Just a couple of brief comments.

I think the difficulty with that is I believe a $117 billion spend on acute care services is too much, and yet making this decision isn't the way you effect that. In an efficient system, we wouldn't be spending that kind of money on hospital services. So that's, I think, a little bit of a frustration.

The only other point I would make is that in many of our comments, we have alluded to a whole variety of different variables that are affecting the financial performance of hospitals or our payment through the Medicare program to hospitals, and I think we actually haven't even talked about all the different variables that may play out, given even some of our own recommendations. And it just might be helpful, if it's not a big deal, to just take a hospital and put together a summary, an inventory, if you will, of all the different payment policy moving parts that could be relevant in the next 12 to 18 months. And I was starting to try to put that together myself, but I think you would be much better able to do that, just to make sure we kind of have that in front of us and we have a sense for how

this particular decision is just one of several moving parts, actually.

DR. REDBERG: I also appreciated the report and the recommendations rationale. I think you really laid out clearly why a lower update can help to restrain cost growth and so I certainly support that, as well as trying to maintain budget neutrality. And the volume growth, I think we have seen clearly that just changing cost per service does not restrain volume, and I'm in particular concerned that at some point we're able to address the relationship between volume and services and patient outcomes, because there is no clear relationship at this time.

And the only other comment I wanted to make, and I don't know whether it's already seen in here, but I've read a lot recently about concerns that with the expanding use of electronic health records and certainly have seen there's a lot of ability to cut and paste and that some of the documentation and coding may be that people are coding for sicker patients that they weren't able to code for previously without electronic health records or that there is just a lot of, because it's so easy, a lot of coding, and whether we've really accounted for that and whether that

trend is going to continue, because it certainly seems that that's the way it's going at this time.

But having said that, I support the Chairman's draft recommendations, both -- in entirety.

DR. COOMBS: Thank you for -- and I appreciate Cori's question regarding the beds, but thank you for clarifying the beds are neither an indicator nor any kind of signifying access adequacy because the beds are maldistributed in different communities. So I think that that's one thing that needs to be assessed in terms of are there deficits where it creates access problems in some communities more than others. I know that, geographically, we've actually seen this in terms of data.

I was surprised that Craig didn't ask the Medicare Advantage question. In Health Affairs, I guess just fresh off the press, in the December issue, there is a growing concern regarding the risk adjustors for the Medicare Advantage in terms of that group of patients having a lower mortality. Now, some of us have been suspicious of that in terms of that there may be a different type of selection process and there may be also a different process of risk adjustment. So that would be something that might be an

advantage to look at regarding the different indicators at the end when we talk about risk adjustments and mortalities from hospital to hospital.

So I think that, in general, that we have to exemplify good stewardship, but in the midst of that, we also have to consider how access may be impaired or enhanced by the decisions that we make. And I'll just wait for the answers to the questions maybe next month, as well. Thank you.

DR. MARK MILLER: So any view on the recommendation?

DR. COOMBS: Generally, I am supportive, but I'd like to see the information of some of the questions that were asked around the table. And I'd also be interested in the stakeholders' response, as well.

DR. DEAN: I would generally support the recommendation with two concerns. One, I certainly agree with what Scott just said, that the overall amount that we spend is too much. This is probably not the way to get at it, partly because of -- that leads to the second concern, is that within this population of providers, there is a tremendous diversity and a tremendous variation in what

their needs are. And I realize we're limited in how much we can respond to individual circumstances given the rules we have to work with, but it's troubled me for a long time that we have to come up with one update across a group of providers that is tremendously variable, some of whom don't need -- probably need money taken away, and others need way more than this process can give them. And that continues to make me very uneasy. But given what we've got, I guess this is reasonable.

MS. UCCELLO: I support the recommendations and I like the framework that we use. And I think it's really important to again highlight something that I think the chapter does a really excellent job of, is that the bottom line here is that when we see negative margins, that doesn't necessarily mean that Medicare is underpaying. And I think the more that we can highlight that in the chapter and elsewhere will be really helpful to people who read our recommendations and the chapter itself.

MR. KUHN: I, too, am generally supportive of the recommendation, although, like Peter and George, I think it's probably -- I'd like us to give some thought about differentiating between the inpatient and outpatient

adjustment, given some of the numbers that we've looked at here. So that's for further conversation on that.

Just -- and one additional just kind of observation about the documentation and coding improvement adjustment that's out there. You know, it's been, what, five years now since CMS put in place the MS-DRGs and we're still adjudicating that adjustment, whether the recovery has occurred, whether it's not, how that's impacted case mix adjustment, et cetera, and that's, you know, will continue to play forward.

But we have an opportunity to get ahead of a similar issue that's coming our way in the not-too-distant future and that's probably when we convert from ICD-9 to ICD-10, and we're going to go through this whole thing all over again. And I know Mark talked about the bandwidth with the staff, and I understand that, and probably not in the work that the Commission has for the coming year, but before we do the cut-over to ICD-10, I think the Commission could do a real service, not only to the provider community but to help the CMS Actuary and many other folks think through what that might look like and project it so that we can have more of a balanced conversation about that for probably the

second half of this decade, because not only will it impact all aspects of fee-for-service, but MA plans, as well, as they look at coding adjustments on a go-forward basis. So across the entire program, it's something we could probably do and look at in the future.

DR. MARK MILLER: I know we're out of time, but I do want to say this about that and other things like that. The way this generally goes is people like us come along and say, you know this is going to happen, and if you just take this effect now, you can have it out of the way. And the estimates that came out at the beginning of the change in the MS-DRG were, you know, about this size, and where we're saying, take this out and be done with it. And the industry was very adamant not to do that, it wouldn't even be that big, and to estimate it later and we'll pay you later. And the estimates are now like this.

And so the point I'm trying to make is that that would also help, if we do that, that the message kind of come pretty solidly, deal with it now because later it just gets bigger. These numbers tend to go up over time.

MR. HACKBARTH: And on top of that, you have this messy process of trying to recoup over a period of years,

which is not ideal.

DR. CHERNEW: So I'm supportive of the recommendations. I want to echo what Cori said about margins being an indicator, but not the only indicator, and I would argue, probably in many ways, not the most important indicator because of all the issues related to knowing what the efficient costs are and a bunch of things. So I do think that's -- Cori said, emphasize it, so I'm glad I got to do that.

The other thing that I'd like to say when thinking about this issue of hospital inpatient and outpatient is we do have to recognize that these services are related in one way or another, and we've had all this other site of care stuff, so when thinking about doing things differentially by a particular area, it's not simply evaluating, what do you think is right for that area, although that matters. It's also about thinking about how services that could be performed in multiple settings are paid, because when we do things differentially, we're changing incentives across site of care in ways that we spend a lot of other time worrying about.

So I'm supportive of these recommendations.

MR. HACKBARTH: Okay. Thank you all.

We will now move quickly to our next session, which is on outpatient dialysis services.

[Pause.]

MS. RAY: Good afternoon. During this session, we will be discussing the adequacy of payment for outpatient dialysis services.

Just a little bit of background. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2011, there were about 365,000 Medicare fee-for-service dialysis patients, roughly 5,600 facilities. Medicare spending total for this section in 2011 was $10.1 billion.

My presentation is composed of two parts. First, I'm going to briefly describe the modernized prospective payment system for dialysis services that began in 2011. Then we will proceed with our adequacy analysis. I will provide you with information to help support your assessment of the adequacy of Medicare's payment for dialysis services. At the end of today's presentation, I will present the Chairman's draft recommendation for you to start your discussion about updating the payment rate for calendar year

2014.

In your briefing materials, there is a section on the use of more frequent hemodialysis and home dialysis by Medicare beneficiaries. This discussion was informed by a panel of clinicians and a patient representative that MedPAC staff convened earlier this fall. There is also a separate section on issues related to access to kidney transplantation. While today's presentation focuses on payment issues, I'm happy to take questions that you might have on these topics. And I would also like to thank Katelyn Smalley and Joan Sokolovsky for their input.

MIPPA mandated that CMS modernize the outpatient dialysis payment method. The statute implements a MedPAC recommendation to broaden the dialysis payment bundle. The broader bundle includes commonly furnished ESRD services including dialysis injectable drugs that facilities were paid separately in prior years. It also includes some services -- primarily lab tests -- that in prior years were ordered by physicians and furnished by independent labs. The new prospective payment system has patient-level adjustments including for age, body mass, three chronic conditions, three acute conditions, and an adjustment for

patients new to dialysis during the first four months of treatment.

The new system also includes a low-volume adjustment that's based on the total number of treatments a facility furnishes, and for facilities that attest to being low volume, their base rate is increased by 18.9 percent.

The new system makes outlier payments applicable to the portion of the broader bundle that was in prior years separately billable -- that is, for dialysis drugs and labs primarily. Under the new payment method, payment is linked to quality. The first year of the Quality Incentive Program is 2012, and in this year the QIP uses clinical performance measures on dialysis adequacy and anemia management that facilities report on their claims.

Finally, most facilities opted into the new payment method -- about 93 percent of all facilities did so -- instead of being paid under the four-year transition.

Your briefing materials included a discussion of four potential issues concerning the modernized prospective payment system. With respect to outliers, CMS in their proposed rule announced that about half of the 1 percent outlier pool was distributed in 2011, and their estimate in

the final rule was about 0.3 percent was distributed in 2011. However, CMS did finalize in the final rule for the 2013 payment system, and they have adjusted the outliers' threshold levels. So we will continue to monitor how this policy is working.

Second, industry has raised concerns about not being able to bill using the comorbidity adjusters because they cannot obtain the necessary documentation from other health care providers. I anticipate getting back to you with a data analysis on this when we meet again in January. We will discuss the third issue of declining use of some injectable dialysis drugs in the payment adequacy analysis a couple of slides from now.

Lastly, we have looked at the performance of the low-volume adjuster under the new payment method. We previously raised the concern that this adjustment does not consider the proximity to the closest dialysis facility. Using 2011 claims data, we found that about 42 percent of the approximately 330 low-volume facilities were within five miles of another facility. There is at least one instance in which a low-volume facility is in the same building as another dialysis facility. Medicare and dialysis patients

might be better served by an adjuster that targets isolated low-volume facilities -- facilities that are not in close proximity to another facility.

So now we will shift gears and move to our payment adequacy analysis.

First we look at beneficiaries' access to care by looking at industry's capacity to furnish care. A direct measure of capacity in this sector is the number of hemodialysis treatment stations. Between 2009 and 2011, capacity grew by about 4 percent per year. And as I will show you shortly, growth in capacity matches growth -- average annual growth rate in beneficiaries.

To look at access, we also look at the number and effect of facility closures. Between 2010 and 2011, there were about 90 facility closures. There was a net increase of about 120 facility between 2010 and 2011. The closed facilities were more likely to be smaller in terms of dialysis treatment stations, more likely to be nonprofit and hospital-based. Few patients -- roughly 1 percent, or 3,800 -- dialysis fee-for-service beneficiaries were affected by these closures. Non-whites, compared to whites, were more likely to be treated in a closed facility. However, there

was no indication that affected patients were not able to obtain care elsewhere. So, to summarize, few facilities closed, few beneficiaries were affected; we do see some difference according to beneficiary characteristics, and we will continue to monitor this.

Another indicator of access to care is the growth in the volume of services. In this sector, one way we track volume growth is by assessing trends in the number of dialysis fee-for-service treatments and fee-for-service dialysis patients. As you see from this chart, these two measures closely track between 2009 and 2011. Treatments increased 4 percent per year on average, and beneficiaries increased 3 percent per year on average.

For this sector, we also look at volume growth by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of dialysis care. Dialysis drugs accounted for about one-third of Medicare's payments to facilities in 2010, the last year that Medicare paid separately for these items. So this chart draws your attention to one drug -- erythropoietin -- that is used to manage patients' anemia, a common renal comorbidity. In terms of Medicare's payments to facilities, again, in 2010,

erythropoietin is the principal dialysis drugs; in 2010 it accounted for about three-quarters of dialysis drug payments and a little under a quarter of ESRD payments.

So using 2009 to 2011 claims data, here you see our preliminary analysis of the changes in erythropoietin use for free-standing dialysis facilities between 2009 and 2011. We measured dose per beneficiary per week. Per capita use was generally steady in 2009, started to decline roughly in August of 2010, and has continued to decline in 2011. Between 2010 and 2011, per capita use declined by 18 percent.

Now, some of this decline is expected for two reasons:

First, clinical evidence has shown an association between higher ESA use and adverse cardiovascular outcomes; this resulted in a change to the drug's label by the FDA in 2011. Indeed, the FDA, in 2011, issued a modified dosing recommendation calling for more conservative ESA dosing for this drug class, and the FDA recommended that providers use the lowest dose in order to avoid a blood transfusion.

The second reason that this decline is expected is concerning the payment change. Under the prior payment

method, when facilities were paid per unit of drug administered, they did not have a strong incentive to control costs of separately billable drugs. Now that dialysis drugs are included in the prospective payment system, facilities have a greater incentive to be more efficient. In your briefing material, we also include findings from researchers, working on behalf of Health and Human Services, that have found a decline between 2010 and 2011 in the use of other dialysis injectable drugs, specifically injectable iron agents that are also, along with epo, used to treat anemia, and injectable vitamin D agents. Two slides from now we are going to discuss the effect of this trend in anemia drug utilization on dialysis quality. If this trend in the declining use of dialysis drugs continues and we see provider profitability improving, we may at some point want to reconsider the level of the base payment rate.

So looking at five-year trends in dialysis quality, for certain indicators measure remain high or are moving in the right direction, and this includes dialysis adequacy, use of AV fistulas. Other indicators suggest quality still needs to be improved. Rates of

hospitalization remain high. Rates of mortality, while trending downward slightly, still remain high. And the proportion of patients registered on the kidney transplant list has remained generally steady over the last five years. Rates of kidney transplantation for dialysis patients has declined over the last five years.

We also this year took a look at changes in dialysis quality between 2010 and 2011 since the implementation of the modernized prospective payment system, and these data were obtained from CMS the U.S. Renal Data System. Mortality hospitalization and emergency department use, while high, have remained steady between 2010 and 2011. As I just discussed, in 2011, use of erythropoietin and injectable iron -- drugs used to manage anemia -- has declined. So we also see a change between 2010 and 2011 in some anemia outcomes. The proportion of beneficiaries with a low hemoglobin level has doubled, and rates of blood transfusion have modestly increased. Blood transfusions are costly; they are not in the broader bundle. Dialysis providers are not held accountable for blood transfusions.

Specifically, for payment years 2013 through 2015, the ESRD Quality Incentive Program does not hold providers

accountable for management of anemia on the low end, such as blood transfusions or increased hospitalizations.

So moving to access to capital, indicators suggest it is adequate. As mentioned earlier, an increasing number of facilities are for-profit and free-standing. Private capital appears to be available to the large and smaller-sized chains.

Moving to our analysis of payments and costs, this analysis is based on 2011 payment data from claims and 2010 cost report data. 2011 cost report data for free-standing facilities is not available. Given the lack of the most current cost report data, we estimate the 2011 Medicare margin at 2 to 3 percent.

So I cannot give you this year the distribution of margins based on facility characteristics. But in prior years, we have seen variation in the Medicare margin, and it has generally been higher for the two large dialysis organizations versus other free-standing facilities; generally on average higher for urban versus rural facilities; and higher for higher-volume facilities versus lower-volume facilities in terms of dialysis treatments.

Moving to the 2013 projection, we projected at 3

to 4 percent, and this projection includes policy changes scheduled to occur in 2012 and 2013.

SO this moves us to the second part of our update discussion. CMS' latest forecast for price inflation for ESRD services for calendar year 2014 is 2.8 percent. Under law, the ESRD update is subject to a multifactorial productivity adjustment that is currently estimated at 0.4 percent. And, in 2014, CMS has estimated a decrease of total ESRD payments by 0.3 percent due to other policy changes, that is, from the Quality Incentive Program.

So that leads us to our Chairman's draft recommendation, and it reads as follows: The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2014. This draft recommendation decreases spending relative to the statutory update.

About the implications, no adverse impact on beneficiaries is expected. Some providers might experience increased financial pressure, but overall a minimal effect on providers' willingness and ability to care for beneficiaries is expected.

That concludes the presentation, and I look

forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Nancy.

Could I get you to put up Slide 14 for a second? So if I understand you correctly, you're saying the projected 2013 margin is 3 to 4 percent, but this is a moving target because we've moved to a new payment system with new incentives, and we've seen an indication, for example, in ESA use, that, in fact, there may be a behavioral response to the new payment system underway. And so I guess the question that I have is the projected 2013 margin. Could you say a little bit more about that? To what extent do you try to project a change in behavior due to the new payment system? Is this a conservative number or a more aggressive number? Could you just talk a little bit more about your projection?

MS. RAY: I would characterize the 2013 Medicare margin as a more conservative projection. We did include the drop in drug utilization in 2011 for ESAs, and we used industry data to model in a small portion of the drop that they have reported for 2012. However, we did not -- other aspects of the assumption are conservative, and perhaps the decline in other dialysis injectable drugs that may be

anticipated.

In addition, there have been reports from the investors suggesting that, in addition the efficiencies from dialysis drugs, there's other efficiencies that they have anticipated realizing from the -- that they anticipate that providers will realize under the new payment method, including from the administration of the labs that are now included in the broader bundle, as well as the increased use in peritoneal dialysis.

MR. HACKBARTH: Jack, do you want to start the clarifying questions [off microphone]?

DR. HOADLEY: Sure. I guess my interest is in the drug piece of this and the erythropoietin decline. It seems like this is a pretty significant -- and you used a figure, I think, of what share of dialysis payments are attributable to the drug piece of this?

MS. RAY: Right. Now, again, that was in 2010, the last year that Medicare paid separately for them. And I think epo was a little under a quarter of all ESRD --

DR. HOADLEY: The point is it's a big piece. You know, is it reasonable to assume that we're going to expect a continuing decline in this as we go into 2012, 2013? How

much further down might you project this could go?

MS. RAY: Well, I think that's a good question. Industry data that's available online already shows a continued drop in 2012, and just looking at differences in dose per treatment between free-standing and hospital-based facilities, hospital-based facilities have historically dosed lower per capita than free-standing, and so hospital-based is still lower than free-standing. So, you know --

DR. HOADLEY: There is more room --

MS. RAY: -- I don't want to predict, but there may be. I don't know.

DR. HOADLEY: And is it reasonable to say that part of the rationale for the recommendation of a zero update is this lower use of the drugs? I don't know if that's a question for Glenn or for you.

MR. HACKBARTH: I'd say it's a significant factor. But, again, it's not the only thing that's changing in response to the new payment methodology. You know, I see this as good news. This is what we anticipated. This is, in fact, why we recommended going to a new pay model. It seems to be coming to fruition so far as we can tell from the available quality measures. It's not coming at the

expense of poorer quality for patients. So this is an encouraging development, as I see it.

DR. HOADLEY: And I guess the only other thing I would ask is, you know, you mentioned there could come a point with some kind of rebasing as needed, what sort of drives the difference between how much of this can be done within the update context versus the need for rebasing.

MR. HACKBARTH: You know, I'd like to hold off on that since this is -- we're in the early stages of this change.

DR. HOADLEY: Okay.

MR. HACKBARTH: The other thing that I think is pertinent here is that the dialysis people were given a choice on whether to move immediately to the new payment bundle or whether to do it on a phased basis -- over four years or three years?

MS. RAY: Four [off microphone].

DR. MARK MILLER: Four. You're right.

MR. HACKBARTH: Four years. And over 90 percent opted to do it immediately. Given this is a largely for-profit business, I think there is a market signal in that choice. I think they went quickly in this direction because

they thought that, in fact, they could reduce costs, and, again, that seems to be coming to fruition. I think a prudent step at this point, at this early phase, is to say no update and hold open the possibility that in the future we will rebase if, in fact, it seems warranted.

DR. HOADLEY: That seems totally -- now, this is a good analysis, and it's always an interesting point when you're getting the early results of a new system. And I was also struck by the fact that they didn't want the phase-in, they wanted to go straight to the new system.

DR. NAYLOR: Just another great report. On the Chairman's recommendation, is the no update still subject to the productivity adjustment?

MR. HACKBARTH: No. It would be a zero update.

DR. NAYLOR: A zero update, no --

MR. HACKBARTH: We recommend numbers, and so we're saying hold the base rate constant.

DR. NAYLOR: Got you. Thank you.

DR. HALL: Just so that we're all on the same page here, the erythropoietin story is a wonderful example of a good scientific principle that didn't work out clinically and turned out to be dangerous and involved a biologic, a

drug that's very expensive. So it's a landmark kind of study and observation.

The question I had was other determinants of costs that might influence our decision, and one of them is: Is there much data on sort of the demographics of new patients coming into dialysis on Medicare? My sense is that it's becoming a much older population. The older the population is on a yearly basis, the more they're likely to require biologics or require a lot of other things. And I didn't see that in the written report, and I just wonder if we could have that information at some point.

MS. RAY: Yeah, it --

DR. HALL: Is it in there? I may have missed it.

MS. RAY: On summary, it can be in there, but I can give you even a little bit more information for the next time. I'd be happy to.

DR. HALL: Thank you.

MR. GEORGE MILLER: It was a very good report, and I'll wait until Round 2, but I really appreciate the information, the demographic information in the report, and I thought it was very well written.

DR. SAMITT: Slide 14, this slide, in the prior

review of payment adequacy in the hospitals, we had talked about the difference between the Medicare margin and the total margin for all payers. Do you have a sense of total margin for all payers? Recognizing that I assume a great percentage of the revenues for dialysis companies comes from Medicare. Do you have a sense of margins all told for all payers?

MS. RAY: We did not calculate a total margin for this sector. What I can tell you, though, based on information from the SEC filings from the two largest dialysis providers is that commercial payers -- and there are -- for new dialysis patients, if they have employer group health coverage and if they choose to maintain it, that will be their insurer, the primary insurer for the first 33 months of dialysis, generally. And so those commercial payers on average do pay at a higher payment rate than Medicare.

DR. SAMITT: Thank you.

MR. KUHN: Two or three quick questions here. One is on the issue that came up earlier on the transition, with 93 percent going in in the first year and 7 percent going through the four-year transition, has any of that additional

7 percent said we want to go all in now, or are they continuing through the four-year transition?

MS. RAY: I think it was a one-time election, and you had to elect it.

MR. KUHN: Gotcha.

MS. RAY: Now, if you opened up a brand-new facility in 2012, I believe -- but I won't swear to it, but I believe that you're under the modernized payment system.

MR. KUHN: And I think I've shared this before, but I would just make this observation. I think it's right, there are some market signals here that it sends as well, but also I think there's another argument to be made that CMS did a very, very good job of putting together this particular prospective payment system, and we oftentimes spend a lot of time criticizing CMS, but I think there's also a time when you want to say, "Job well done," and I think the agency got this one right, and I think they deserve the credit for doing that as we go forward.

Another quick question is on the closure of facilities, and I know you're going to come back and talk about this some more, but were any of the closures in rural areas on that? Because that does really present an access

issue when you look at some of the travel times for some folks going to dialysis facilities.

MS. RAY: Let me get back to you on that next month.

MR. KUHN: And on the issue of erythropoietin and the whole use of ESAs, under the old composite rate system, CMS used to run a hematocrit monitoring program. Does that program continue to this day? And is that data still available to look at in terms of what's going on in terms of ESA use for the dosing levels?

MS. RAY: Right.

MR. KUHN: Okay.

MS. RAY: So the claims are still reporting the number of units administered, and they are still applying that edit, to my understanding, as to claims that are reporting too high based on that monitoring policy.

MR. KUHN: But unlike in the previous regime under the composite rate where it could impact payment if they were dosing at too high levels --

MS. RAY: Right.

MR. KUHN: -- because now the PPS system, it's not impacting payment one way or the other?

MS. RAY: It could, if they were -- if it then made them eligible for an outlier.

MR. KUHN: Okay

MS. RAY: So that's why I believe they are still using that.

MR. KUHN: Okay. And then the final quick question is: On this patient comorbidity adjuster, I think we're going to come back and learn a little bit more about that, but I'm still troubled that now we've had this program up for a year and the dialysis centers are still having trouble billing for that as we continue to go forward. That seems to be a real problem, and any thoughts that we can have on that to help with CMS and others in that area -- I don't know what we could do in that area, but it just seems like that whole disconnect of here a physician might see a patient, they might have the information, but somehow that information is not available to the dialysis center so they can't code and bill for it is troubling.

MS. RAY: Right. Well, and let me be clear, what we've learned in discussions with dialysis providers is yes, they may know that the patient was hospitalized for such a comorbidity but they need the actual paper documentation.

And that is what --

MR. KUHN: Right. Is the hold up.

MS. RAY: -- is the hold up.

MR. KUHN: Okay, thanks.

MS. UCCELLO: So in terms of these anemia levels and measures, it looks like there's a lot of good news here, on one hand; right? That the two high hemoglobin counts have gone down. But it also looks -- if I understand things correctly, there is a concern that there's an increase in levels that are too low. Am I understanding that right?

MS. RAY: The ESA management, I mean there's definitely a little bit of uncertainty here because when the FDA came out in 2011 and came out with their more conservative dosing what they said is -- and again, I'm not a clinician, but my understanding is of what the FDA said as well, provide sufficient ESA dosing to avoid blood transfusions.

So while we do see a doubling of folks on the lower end of hemoglobin, we only see a very, very small modest increase in the blood transfusions. So I really think it's the blood transfusions and hospitalizations and maybe some -- we could do some thinking of some other

indicators to think about that would detect the quality here.

MS. UCCELLO: And can you remind me whether and how this is incorporated into the quality part of the payment?

MS. RAY: Yes, that's a good question.

So for 2012, in the quality incentive program, there were two anemia measures. One, that was weighted 50 percent, looked at the proportion of a facility's patients with a low hemoglobin level. And then 25 percent of the score was based on a high hemoglobin level. And the last 25 percent was based on dialysis adequacy.

Beginning with the 2013 quality incentive program, CMS removed the lower end performance indicator because of the FDA announcement because the FDA, in their revised label, did not include a specific floor, a specific hemoglobin floor, and they did not include a range.

So CMS, in their judgment, removed the lower level quality incentive indicator from the program.

DR. MARK MILLER: And that's kind of where we're stuck. I mean, this conversation started out a few years ago about ranges of levels. Then people have sort of, the

clinical types have sort of said well, we're not going to say these levels. And so people like us are a little bit stuck. And I think Nancy's main message is so what we ought to be thinking here under PPS is what quality measures do we track that if they're doing too little of it people start bouncing to the hospital, transfusions, that type of thing.

DR. DEAN: Just to follow up on Cori's question, do we have any data about how much variation there is from program to program in terms of the incidents of anemia? I mean, there's obviously a pretty dramatic change. The percentage of high hemoglobins have dropped quite dramatically. The number of low hemoglobins has increased quite dramatically. So far that doesn't show up in hospitalizations. Whether or not it will, I think, is still an open question.

I just wonder, is this a uniform observation or does it vary much from program to program? Or can we answer that?

MS. RAY: What I can tell you today is the drop in per capita use of epo is pretty consistent across the different types of providers. What I'll have to get back to you in January is to see if I can look at the drop in

hemoglobin levels across different provider types. I don't have that information right now.

DR. COOMBS: Nancy, great job. And because of your wonderful research in putting this together and all of your support, I have very few questions. I just have a comment about the acuity and disparity for the transplants. I thought that was really, really remarkable and it's compelling.

I think that the world of nephrology has done and exceptional job and this is a template or a poster child for the other disciplines, including cardiology and the like, for common diagnosis, I think.

Just great job. I support the recommendations and you can skip me on round two.

DR. REDBERG: Excellent report.

I was interested, I wanted to delve into a little bit more why you think there's -- if you have any insight why there's so few percent of patients that are on home dialysis or peritoneal dialysis? Because generally it's more comfortable, you're not going to a dialysis center. The quality measures all look about the same for peritoneal dialysis and hemodialysis at a center.

I did see some reference, I think the reimbursement rate is much higher for providers in a dialysis center. I don't know if that's influencing it.

But in surveys I've seen, a lot of patients say they're not offered the option of peritoneal dialysis. I know you had some discussion groups and I'm wondering if you had anymore insight into that?

MS. RAY: I think the use of peritoneal -- I think the declining use of peritoneal dialysis beginning in the 1990s, up until fairly recently, I think it's been multi-factorial. I think part of it is patients are not informed their treatment options even before they start dialysis and after dialysis.

And I think later on, in the spring, we're going to talk about shared decisionmaking and I think this is one area where that could be an important tool.

I have heard and read that nephrology training programs don't -- you know, could be doing a better job at teaching home dialysis so that a lot of nephrologists don't feel comfortable with home dialysis. So there's that.

Under the prior payment method, when drugs were paid separately in-center hemodialysis patients, on average,

got more drugs than the home peritoneal patients. So for some providers, you know, the in-center could be a little bit profitable.

Under the newer payment method, however, the good news is that incentive has kind of changed because now that the drugs are included in the bundle, peritoneal dialysis has been -- when you look at just the dialysis treatment costs, setting aside the drugs, has been historically cheaper than in-center hemodialysis. And so we do see a small movement and increase in peritoneal dialysis in overall numbers.

And I have heard that from providers coming in as well, saying they are considering more peritoneal dialysis for their patients.

So hopefully, with increased education and with new payment methods, maybe.....

DR. REDBERG: The other point, in the tables like table 3, I notice in general -- well, we dialyze a lot more people per capita in the U.S. than anywhere else in the world and our outcomes are much worse than anywhere else in the world. Kind of looking into -- as a clinician when I see -- you know, we dialyze a lot more on the older, people

that probably are not getting any quality of life or mortality benefit from dialysis.

And also, what is concerning is now we're also dialyzing more on the other end. And so there's a trend to starting earlier dialysis. There have been several studies published in multiple journals over the last few years showing that early dialysis does not offer any benefit and, obviously, it's a decrement in quality of life as well as other things. I'm wondering if there's some way that we can address that issue because I think it's not -- it's costing a lot and it's harming our beneficiaries.

And I wonder if it's the increase in dialysis that's leading to this overall lower rate of transplantation. There's probably a fairly finite supply of kidney donors and kidneys available and the rates of transplantation going down just because we have the same donor supply and more and more people on dialysis.

But I am concerned, and maybe we'll come back to it in round two or another time, on the relationship between volume of dialysis and outcomes.

And our outcomes measures, they're more process measures than they are kind of quality of life and things

that -- these measures don't tell me a lot about how a patient feels. It's just lab measures and what kind of fistulas. so maybe when we talk about shared decisionmaking we can also look at more patient-oriented outcomes measures that are actually clinically meaningful.

MS. RAY: Yes, I just want to -- there is no available data source for me on patient satisfaction that I can include in this table. However, the dialysis quality incentive program beginning in 2014 does -- a part of the QIP does include whether or not the facility surveys their patients using the -- their in-center hemodialysis using that CAHPs form or that patient satisfaction form.

MR. HACKBARTH: [off microphone.] Jack, round two.

DR. HOADLEY: I think the zero update makes pretty good sense here so I'm happy with the recommendation.

DR. NAYLOR: As am I.

DR. HALL: I am happy with it.

MR. GEORGE MILLER: Yes, I agree with the update recommendation but I do want to echo what Rita said earlier because that was exactly my point for round two.

I am a little concerned, and I guess the question

is is this the best the health care community can provide for patients who need this? I am struck by the large percentage of African-Americans who are in this group. It doesn't make sense to me -- and I'm not a clinician, but it just doesn't make sense to me.

Older Americans get it, as Rita said, the evidence is not that it does any good. The outcomes are not good. And the fact that the number of patients that quality for transplants has gone down is another indication there maybe an issue with supply or other issues.

In other sectors, we said is there too much capacity? Should we be closing down hospitals? Fair question.

The question here would be is this the best we can do? And are we paying for what we're getting? And if you compared this against other countries, why do we do so much more for little benefit? And should we be paying -- is this the best we can do versus should we be paying for it?

Because obviously some patients actually need it. But the growth rate, the outcomes being poor compared to other hospitals, it raises a lot of questions in my mind.

MR. HACKBARTH: To the extent the concern is that

too many patients are dialyzed, whether too many old patients, whether dialysis is begun too early as Rita suggested, as we discussed in the context of hospital I don't think that you're going to effectively address those issues by manipulating the payment rate per dialysis session. You need to go to new models of payment and care delivery.

One of my frustrations in this area has been -- I believe it's still true -- that Medicare Advantage, dialysis patients cannot enroll in an MA plan. If they develop the need for dialysis once they're in, they can stay in. I think it was like in the year 2000 we recommended that dialysis patients should be permitted to enroll in the first instance and get in an environment where there are appropriate incentives to manage services. But they still haven't changed that, I don't think.

MR. GEORGE MILLER: I don't disagree, this is not the method because we're dealing with update. But I still think the question should be asked. I mean, we're paying for a service for the beneficiaries. So the question is if the evidence isn't there, should we be paying for this?

MR. HACKBARTH: And I didn't mean to say that

these weren't issues that we shouldn't raise in the text. I just don't think that the update is --

MR. GEORGE MILLER: I'm going to support the update.

MR. HACKBARTH: -- a lever for affecting those decisions.

MR. GEORGE MILLER: Right, I'll support the recommendation for the update but I'll still raise the questions.

MR. HACKBARTH: Yes. Craig.

DR. SAMITT: Great job, Nancy.

I support the recommendation fully, and I would echo Rita and George's comments and Glenn's recommendation for when and how we can potentially address this in the future. I think that is a concern.

DR. NERENZ: A quick comment. Glenn, you said more or less what I was thinking to say but I'll just slightly paraphrase here that I think the prospective payment system that we have here is still a per unit of dialysis payment. It seems like there's a tremendous opportunity here, when we look at the high admission and readmission rates, to move to a much broader bundled --

whether it ultimately is capitated, who knows -- but things that would include then incentives to do more care coordination, more work that would not be part of the payment that we currently have.

But different discussion for a different day.

MR. HACKBARTH: One of the other developments, as I understand it, in this field is that there are at least some people who think that more frequent dialysis would be a good thing. And so if you went to a payment system that did not pay per unit of service, then you'd have to say how do we make sure if, in fact, more frequent dialysis is a good thing, how do we create the appropriate incentive for that and don't create an incentive to skimp?

DR. MARK MILLER: Did you have a comment on the recommendation, David?

DR. NERENZ: [off microphone.] Yes.

MR. HACKBARTH: Kate?

DR. BAICKER: I'm supportive of the recommendation and of the broader move towards larger but smarter bundles

MR. BUTLER: I support the recommendation. I would cite in the -- Rita cited the home dialysis and the appendix. I wouldn't leave out what we learned from

ambulance service, when you reference -- the path of least resistance is the transport. And the cost of that, we learned, was even in excess of the total cost of dialysis in some case.

So as you look at that, think about that as a variable to maybe have a sentence or two around in the appendix.

DR. CHERNEW: I'm supportive of the recommendations as they are. I think this notion of figuring out how we measure quality no matter what we do is going to be true here and a whole slew of other places when we spend our time. I think it's just going to be a general theme.

MR. KUHN: Yes, I support the recommendations.

MS. UCCELLO: I support the recommendation and I also think we need to look at this low volume adjustment, which doesn't seem to make sense if there's a facility in the same building as another one.

Another thing is that these racial disparities in transplantation are a concern and it's appropriate to try to think about initiatives that can help Medicare reduce these.

But I think this is also an area that is

especially ripe for prevention. This is something that's going to be outside of Medicare. But I think this just seems like that's where more focus needs to be.

DR. DEAN: I support the recommendation.

DR. COOMBS: I was going to skip but I wanted to just point out to the Cori and the ones around the table that the disparities in transplantation for African-Americans was far worse than this. This is, indeed, an improvement. Nancy well tell you.

DR. REDBERG: I support the recommendation and the only add -- and Cori just mentioned it. You had mentioned changing it to an isolated low-volume adjuster and that would make sense. It doesn't make sense to me to have a low-volume adjuster because it just encourages low volume facilities that aren't necessarily needed.

MR. HACKBARTH: That sort of standard MedPAC recommendation related to low volume. It should also be for isolated providers.

Scott.

MR. ARMSTRONG: I support this, too.

I would just add that when we get a chance to talk more about shared decisionmaking and its application, I

would pay money to these organizations if they complied with the evidence driven discussion about the different options. But that's different than what we're deciding on now.

MR. HACKBARTH: Okay, good job. Thank you, Nancy.

We will now have our public comment period.

In the interest of time, I will not repeat what's on the screen. These are the ground rules on the comment period.

When this light comes back on, that signifies the end of your two minute period and I ask you to quickly conclude at that point.

MS. STEINBERG: Good afternoon. I'm Caroline Steinberg with the American Hospital Association.

I would like to make a comment with regard to the coding offset.

MedPAC recommend acuity adjusted DRGs to improve payment accuracy by better accounting for differences in payment acuity across hospitals. This concept is equally applicable over time. The notion that payment accuracy should be compatible with budget neutrality is severely flawed.

Numerous indicators suggest that patients are

getting sicker. Rates of chronic conditions are increasing. More beneficiaries have multiple chronic conditions. And all of these things need to be managed when they are in the inpatient setting. Use of ICU beds is increasing. Care is shifting to the outpatient setting, leaving more sicker patients in the in-patient setting.

Most importantly, when you apply the more accurate MS-DRG system to historical claims what you actually find is the case-mix was increasing before its implementation, even before there were incentives for improved coding. Despite these trends, to get the $11 billion that MedPAC suggests and CMS suggests in overpayments would imply that real case-mix has actually been declining.

I would encourage MedPAC to make their calculations more transparent on that issue.

By assuming the case-mix measured under the old, less accurate, DRG grouper and the new improved MS-DRG grouper should be equal -- which is what budget neutrality implies -- makes no attempt to separate real case-mix from coding change which is, in fact, what the statute required.

Thank you.

MS. UPCHURCH: If I may, to Rita's question about

utilization before I start to comment, there is a medical evidence form that has to be completed for a patient to cover of Medicare coverage of ESRD. So that limits some of the early starts that you were talking about. so there is a process in place to limit that.

My name is Linda Upchurch and I represent NxStage Medical. We're a Massachusetts based device company and the leading innovator in the field of home hemodialysis.

We applaud MedPAC for your appropriate focus on the benefits of and access to home hemodialysis during 2012 and encourage you to continue to study the ongoing barriers to expanded use of home hemo. Your accurate and consistent comments over the past several years relating to inadequate payment for home training services reflect an unresolved need to update the training payment for resource intensive home dialysis training.

This remains a timely and urgent issue. I think the first line of a recent published article from the American Society of Nephrology's dialysis advocacy group says it all. The first line reads "Home hemodialysis is a severely underused modality in the United States."

The facts support this. Even though most

clinicians would themselves choose those modality, less than 2 percent of the dialysis population gets this therapy and fewer than one in four dialysis centers even offer it to patients.

MedPAC has cited the clinical benefits in prior publications and these data only grow stronger. With the survival, cardiovascular health and quality of life benefits home hemo is proven to provide, as well as the fact that more of these patients are transplanted, it's an injustice that so few patients have access. Home hemo is an important part of patient-centered care.

Despite good intentions, bundle has not materially increased patient access to home hemo. We routinely hear from exasperated patients and families denied access simply because they are Medicare beneficiaries.

I urge you to confirm this data with CMS and through the United States Renal Data System.

Payment remains a significant barrier and, more specifically, payment for patient training is grossly inadequate. It does not sufficiently cover the critical upfront investment to train a patient and his or her caregiver to safely and effectively perform home

hemodialysis therapy in their home. Moreover, there are specific differences in training for home hemo versus PD that significantly disadvantage home hemodialysis. Inadequate payment for training has a real impact on patient access.

Again, it is an injustice to patients that most do not even have a chance to choose a therapy that most physicians and nurses would choose for themselves. CMS has stated previously that they would address this, but it has not been resolved.

We believe MedPAC could have significant positive impact on patients' lives by urging CMS to adequately pay for home hemodialysis training.

Thank you.

MR. HACKBARTH: Okay. We will adjourn for lunch and reconvene at 1:45.

[Whereupon, at 1:02 p.m., the meeting was recessed, to reconvene at 1:45 p.m., this same day.]

AFTERNOON SESSION [1:56 p.m.]

MR. HACKBARTH: Okay, it is time to begin our afternoon session.

Before we turn to payments for physicians and other health professionals, let me just say a few comments for our audience about the process that we're engaged in.

As I think everybody knows, we are, this month, considering draft recommendations on payment updates and we will be making and voting on final recommendations at our January meeting. By statute, under the statute that created MedPAC, what Congress has asked us to do is make payment recommendations that are consistent with the efficient delivery of services, and to do so while considering the budgetary impact of our recommendations.

As folks know who have followed this work over a period of years know, we use a multiple-part payment adequacy framework which will be illustrated here in our first session on physician payment. And our practice for each of the provider sectors is to start with the existing base rates and then examine evidence on the factors in our payment adequacy framework to decide whether the existing base rate should be increased or decreased relative to the

current rate.

This year, with the sequester, that becomes a little more confusing. And so, I've asked Kate to make a brief explanation of how the sequester factors into our update recommendations for this year.

So Kate, do you want to walk people through that?

MS. BLONIARZ: The Medicare sequester starts in 2013, in February, and cuts 2 percent from nearly all provider payments. This chart is supposed to represent how it would work for an example sector.

The sector receives a statutory update each June. The yellow line shows the payment in the absence of the sequester. The dashed green line shows the payment when the sequester begins in February 2013.

The updates that the Commission is considering today and tomorrow are based on the yellow line. They are considered updates to the base rate of payment.

The presence of the sequester will affect the savings estimates for the Commission's recommendations. In the first example, a sector has a base rate of $100 in 2013 and a statutory update of 1 percent. In 2014, the payments would increase by $1 for the update and decrease by $2 for

the sequester to $99. If the Commission recommends a 1-percent update for 2014, this would result in a payment amount of $101, and compared with the sequester baseline, the Commission's recommendation would have a cost.

The second example shows a sector with a base rate of $100 and a update of 1 percent, and, again, the sequestered amount for 2014 is $99. But for this sector, the Commission recommendation is a negative 2-percent update, resulting in a payment rate of $98. And compared with the sequester baseline, the Commission's recommendation would score as savings.

So the recommendations may result in savings or costs relative to the sequester baseline based on what the statutory update and the update recommendations are.

MR. HACKBARTH: Would you put up the graph, Kate?

So in this illustration, what the Commission will be focused on is that yellow line and the size of the steps or declines in the steps, as the case may be. The sequester runs off to the side.

To reiterate what Kate said, in some instances our final recommendation may be above the sequester line. In some cases, it may be below. Where our recommendation is

above the sequester line, that means we don't agree with the sequester for that particular service. Where our recommendation is below the sequester line, we think that, in fact, the rate should be lower than provided under the sequester.

One way to think about our work is what we are trying to do, what we've been charged to do by the Congress, is to help them come up with potentially better alternatives to an across-the-board sequester where there are targeted opportunities for achieving Medicare savings.

This afternoon we are considering three areas: physician and other health professionals; skilled nursing facilities; and home health care services. In each of these three areas, MedPAC has a standing multi-year recommendation for changing payment policy for physicians, skilled nursing facilities and home health agencies. Therefore, we will not be voting on a separate update recommendation for each of those areas. What we will do in our March report is rerun our earlier multi-year recommendation.

Having said that, we will provide all of the updated analysis on the various payment adequacy indicators, so that's available to the Congress. And of course we will

have, I'm sure, a real robust discussion about the implications of those payment adequacy factors.

Have I covered it all? Mike, anything to add?

DR. CHERNEW: [off microphone.] No, I think you're good.

MR. HACKBARTH: Okay. Thank you, Kate. I appreciate it.

With that, we will turn to physician services and other health professionals. Dan, are you leading the way? Kate is leading the way. I was wishing you so long. Welcome back, Kate. I missed you.

[Laughter.]

MS. BLONIARZ: This session will cover two topics: Kevin and I will summarize our analysis of payment adequacy for fee schedule services, and Ariel and Dan will do the same for Ambulatory Surgical Centers. And I want to thank Lauren Metayer and Katie Smalley for help with a variety of analyses.

Some background on Medicare's payments to physicians and other health who deliver office visits, surgical procedures, and range of diagnostic and therapeutic services in all settings. Total Medicare spending was $68

billion in 2011, or about 12 percent of total outlays.

There are about 850,000 practitioners actively billing Medicare -- 500,000 or so are physicians and the balance are nurse practitioners and other advanced practice nurses, physical and occupational therapists, chiropractors, and other health professionals.

Nearly all beneficiaries received a fee schedule service in 2011, and Medicare paid for around 1 billion services total.

To assess payment adequacy for physicians and other health professionals, we review access to care, including our own survey of beneficiary access to ambulatory care, and other national beneficiary and provider surveys, volume growth, quality, the ratio of private insurer payments to Medicare's payments, and other measures of financial performance. Because physicians and other health professionals do not report their costs to Medicare like some other sectors, we are not able to directly assess Medicare's payments in relation to providers' costs, and use proxies instead.

Every year, we contract for a telephone survey of 8,000 Medicare beneficiaries and insured individuals age 50

to 64 to assess their access to ambulatory care; the survey was fielded through the summer and fall of 2012. Overall, we find that most Medicare beneficiaries are able to get timely appointments: 77 percent of beneficiaries reported they never had to wait longer than they wanted for a routine appointment, and 84 percent said they never had to wait longer than they wanted for an illness or injury appointment. And these numbers are higher those reported for the privately insured individuals in our survey.

We continue to see minority beneficiaries reporting that they have more trouble accessing specialty care. Black beneficiaries are more likely to report that when they had to wait longer than they wanted for an illness or injury appointment, they went to the emergency room instead.

We don't see significant differences in access across rural and urban beneficiaries, with nearly the same shares reporting that they could see a doctor when they wanted to.

We also look at some other beneficiary and provider surveys, as well as our own beneficiary and provider focus groups. And in general, we find similar

things to our access survey: beneficiaries report that they have a regular source of care and can see them in a timely way.

Another question of interest from our survey is how often individuals face problems finding a doctor. In 2012, a very small share of respondents were looking for a new physician: 7 percent of Medicare beneficiaries were looking for a primary care doctor, and 13 percent were looking for a specialist.

The top left pie is for primary care doctors. Of those that are looking -- most beneficiaries (93 percent) aren't looking for a primary care provider. But of those that are, 4.7 percent had no problem, 0.9 percent had a small problem, and another 0.9 percent had a big problem. A similar pie on the bottom right is for specialists.

In comparing the two pies, when beneficiaries are looking for a primary care provider, they report big problems more often than those looking for a specialist. And this finding of beneficiaries having more trouble accessing primary care is consistent with prior surveys.

We assess ambulatory care quality using a set of measures developed for the Commission called the MACIEs. Of

the 38 measures in the measure set, between 2008-2009 to 2010-2011, 20 were unchanged, 12 improved, and 6 declined. The increases and decreases in quality were small. A number of cancer screening measures declined slightly, which also matches findings in a survey of private insurance plans, and is likely due to ongoing questions on the frequency and efficacy of cancer screening. One potentially avoidable hospitalization measure -- for hypertension -- also worsened slightly.

So I'll turn it over to Kevin now to talk about volume and other measures.

DR. HAYES: This slide summarizes our work with claims data to analyze changes in the volume of fee schedule services per beneficiary.

Across all services, volume per beneficiary grew from 2010 to 2011 by 1 percent.

Looking at different broad categories of services, the volume of evaluation and management services grew at a rate of 2 percent.

However, starting in 2011, PPACA expanded coverage to include annual wellness visits. If we exclude wellness visits from the calculations, the growth rate for E&M was

1.1 percent.

The volume of imaging services decreased by 1 percent. I'll say more about that decrease in just a moment. And the volume of major procedures decreased by 1.1 percent.

The volume of procedures other than major procedures increased by 1.9 percent, and the volume of tests increased by 0.8 percent.

On the decrease in use of imaging, let me make a couple of points.

First, the Commission and others in the policy community have paid particular attention to these services. Cumulative growth in the volume of imaging from 2000 to 2009 was 85 percent. The cumulative decrease in imaging volume over the next two years, from 2010 to 2011, was less than 4 percent.

Second, there has been much commentary in clinical journals about the necessity of some imaging services. For example, there's a concern that while sophisticated technology can detect disease, it can also have costs that include exposure to radiation, adverse effects of treatment, and proliferation of false positive results. These points

are discussed further in the draft chapter.

We note also that much of the imaging decrease was due to a change in setting for cardiac imaging. During the previous session on hospital services, it was noted that there has been a shift in delivery of echocardiography from professional offices to hospital outpatient departments. The numbers for echocardiography were presented then, so there's no need to go over them again. You see similar numbers on the slide for nuclear cardiology.

For this presentation, let me just say that some of the decrease in imaging volume is due to this shift in setting for cardiac imaging.

Growth in the volume of services accounts not just for a change in the number of services furnished but also any change in the relative intensity or costliness of the resources used in furnishing those services.

With the shift in setting for cardiac imaging, some of the billing for these services remains under the physician fee schedule, albeit at lower rates because of the shift in setting; but increasingly the billing for these services is under the outpatient prospective payment system. In turn, the shift reduces the volume of fee schedule

services.

If cardiac imaging is excluded from the calculations, the change from 2010 to 2011 in the volume of imaging services billable under the fee schedule would not be a decrease of 1 percent. Instead, it would be an increase of half a percent.

Let me also mention that a contractor has conducted a study for the Commission on repeat testing. The list of services considered includes three types of imaging services: echocardiography, imaging stress tests, and chest CT.

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

With few standards available to judge the appropriateness of repeat testing, it appears that the variation is explained largely by local practice style. The study also raises questions about whether the levels of repeat testing observed represent an effective use of physician time.

In addition to payment adequacy indicators on access, quality, and the volume of services, we consider other indicators. The ratio of Medicare to private PPO rates continued at 80 percent for 2011 -- about the same ratio as the previous year. Among physicians and other professionals billing Medicare in 2011, 96 percent were "participating," which means that they accept assignment on all claims. Fully 99 percent of allowed charges were paid "on assignment" in 2011. Recall that assignment means that the practitioner accepts the fee schedule allowed charge as payment in full.

The equity of payments under the fee schedule is another issue that the Commission has been concerned about. In addition, some physicians assert that they lose money when furnishing services to Medicare patients. Looking at physician compensation data for 2010, we see that actual annual compensation for primary care physicians averaged $207,000. By contrast, actual annual compensation for physicians in non-surgical procedural specialties averaged $445,000. Simulating compensation as if all services were paid under Medicare's fee schedule, the disparity remains: $170,000 for primary care and $398,000 for the non-surgical

procedural specialties. Either way, compensation of the non-surgical proceduralists was more than double that of primary care physicians. When considering this issue, the Commission has expressed concerns about such disparities. The disparities raise concerns about mispricing and the ability of physicians in some specialties to generate volume.

For further perspective on payment adequacy in this sector, remember that fee schedule spending is a function of payment per unit of service and the volume of services. Payment per unit of service has been rising according to payment rates, shown here as the yellow line; spending per beneficiary is represented by the red line. It includes the updates but also growth in the volume per beneficiary.

Next, Kate will review the Commission's position on the update formula for these services, the sustainable growth rate system.

MS. BLONIARZ: So an overarching issue affecting the Commission's deliberations is the sustainable growth rate system, or the SGR. Under the SGR, payments for physicians and other health professionals would be cut by

around 27 percent on January 1, 2013. The Commission laid out its findings, principles, and recommendations for moving forward from the SGR system in its October 2011 letter to Congress, and I will recap the Commission's letter over the next three slides.

The Commission found that the SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. Specifically, the SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth. Second, temporary, stop-gap fixes to override the SGR undermine Medicare's credibility. And, third, the cost of repealing the SGR continues to grow, creating pressure to repeal it now. And potential Medicare offsets are being used for other purposes.

The Commission's principles for moving forward from the SGR are: the link between cumulative fee schedule expenditures and annual updates is unworkable and should be eliminated; beneficiary access to care should be protected; and proposals to replace the SGR must be fiscally responsible.

This year, for the update for physician and other

health professionals in 2014, the Chairman proposes to maintain the Commission's SGR recommendations. Those recommendations are summarized as follows: first, repeal the SGR and replace it with ten years of legislated updates; second, collect data to improve payment accuracy and identify overpriced services; third, incent movement into ACOs by improving the shared savings baseline; and, fourth, if the Congress decides to fund the SGR fix entirely within the Medicare program, this would require offsets across Medicare -- specifically, within physician, a freeze in the payment rate for primary care and a reduction in payment rates for all other physicians, offsets in other provider sectors, such as hospitals, SNF, home health, and others, and higher out-of-pocket costs for beneficiaries.

So, with that, I'll turn it to Ariel and Dan on ASCs.

DR. ZABINSKI: Important facts about ambulatory surgical centers in 2011 are: first, that Medicare payments to ASCs were about $3.4 billion; the number of fee-for-service beneficiaries served in ASCs was 3.4 million; and the number of Medicare-certified ASCs was 5,344.

In addition, 90 percent of ASCs have some degree

of physician ownership. These physician owners may furnish more surgical services in ASCs than they would if they had to perform them in hospital outpatient departments, which is the sector with the greatest overlap of surgical services with ASCs. And, finally, the ASC payment rates are scheduled to receive an update of 0.6 percent in 2013.

An important factor to consider in regard to the payment adequacy of ASCs is the benefits and concerns of ASCs relative to HOPDs. One benefit is that ASCs offer efficiencies relative to HOPDs for both patients and physicians. In addition, ASCs have lower Medicare payment rates than HOPDs, which can result in lower aggregate payments for Medicare and lower aggregate cost sharing for patients.

But there is a concern because most ASCs have some degree of physician ownership, and evidence from recent studies indicates that physicians who own ASCs perform more procedures and that markets that had ASC entry had higher growth in colonoscopies and upper GI tract endoscopies than markets that did not have any ASC entry.

Therefore, it is possible that physician ownership of ASCs can offset some of the reduced spending and cost

sharing that can result from having services provided in ASCs rather than HOPDs.

As part of our analysis, we compared the profile of the patients who have ASC-covered services performed in ASCs versus those who have those services done in HOPDs.

Relative to the ASC patients, we found that the HOPD patients are more likely to be dual eligible, minority, under age 65, and age 85 or older.

We also investigated differences in patient severity between ASCs and HOPDs by comparing 2010 CMS-HCC risk scores for patients receiving care in those two settings. We found that beneficiaries with higher risk scores are likely to be sicker and may require more time and resources to treat. We found that the average risk score is higher among HOPD patients than ASC patients. But HOPD patients do not have higher risk scores across all services. In particular, in services that account for 70 percent of Medicare ASC volume, the average risk scores are not significantly higher among the HOPD patients.

Then in our assessment of payment adequacy of ASCs, we use the following measures: beneficiaries' access to ASCs and overall supply of ASCs; ASCs' access to capital;

and aggregate Medicare payments to ASCs.

We are unable to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS. In addition, we cannot assess quality of care because ASCs only began submitting quality data last October.

We found that the measures of payment adequacy were generally positive in 2011, as the number of fee-for-service beneficiaries served, the volume of services per fee-for-service beneficiary, the number of Medicare-certified ASCs, and Medicare payments per fee-for-service beneficiary all increased.

But this table does indicate that the growth rates of all of these measures are lower in 2011 than in previous years, and several factors may have contributed that slowdown such as the slow recovery from the economic downturn that occurred in the fall of 2008; investors responding to the substantial revision of the ASC payment system in 2008; much higher Medicare payments when a service is provided in an HOPD than in an ASC, which may have led some ASC owners to sell their facilities to hospitals; and more physicians becoming hospital employees. And as this occurs, physicians may be more inclined to provide surgical

services in hospitals rather than ASCs.

To evaluate ASCs' access to capital, we examined the growth in the number of ASCs, as capital is needed for new facilities. This analysis indicates that access to capital has been adequate. As we saw on the previous slide, the number of ASCs grew at an annual rate of 3.6 percent over 2006 through 2010. But the rate of growth has slowed, increasing by 1.8 percent in 2011, perhaps due to the factors discussed on the previous slide.

Now I'll turn things over to Ariel, who will discuss ASC quality reporting and a draft recommendation.

MR. WINTER: As Dan just mentioned, we do not have quality or cost data for ASCs. However, CMS has adopted a quality reporting program for ASCs under which the ASCs will begin reporting five claims-based measures -- or began reporting five claims-based measures in October. And ASCs that do not report these measures will receive a lower update in 2014.

But payments to ASCs will not be affected by how they actually perform on these quality measures. In fact, CMS does not have the statutory authority right now to establish a value-based purchasing program for ASCs that

would reward high-performing facilities and penalize low-performing facilities.

In our most recent March report, we recommended that Congress direct the Secretary to implement a value-based purchasing program for ASCs by 2016, but this recommendation has not been adopted.

Next slide, please.

So, in summary, we find that access to ASC services continues to increase, as shown by growth in the number of beneficiaries treated, volume per fee-for-service beneficiary, and the number of ASCs. In addition, growth in number of ASCs suggests that access to capital has been adequate. However, our analysis of payment adequacy is limited because we do not have cost or quality data. And the Commission has recommended several times that ASCs be required to submit cost data. Such information would allow us to determine the costs of an efficient provider, which would help inform decisions about the ASC update.

In addition, CMS uses the consumer price index to update ASC payments, and the Commission has raised concerns that this index may not reflect the structure of ASC costs.

If cost data were to be collected, they could be

used to identify an appropriate input price index for ASCs. However, there is currently no plan in place to collect cost data from ASCs.

Next slide?

So here we have the Chairman's draft recommendation: The Congress should update the payment rates for ASCs by 0.5 percent for calendar year 2014. The Congress should also require ASCs to submit cost data.

Next slide, please?

So we have the implications. With regards to spending implications, under current law ASCs are projected to receive an update in 2014 of 1.5 percent. Therefore, relative to this statutory update, this draft recommendation would produce small savings.

With regards to implications for beneficiaries and providers, because of growth in the number of ASCs and the volume of ASC services, we do not anticipate this draft recommendation would diminish beneficiaries' access to ASC services or providers' willingness or ability to furnish services.

And, finally, ASCs would incur some administrative costs to submit cost data.

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

MR. HACKBARTH: Okay. Thank you. Well done.

So what I would like to do is begin with a few comments about MedPAC's recommendations related to SGR. Some of what I say will repeat things that were said during the staff presentation, but some of it will be new.

I think it's important to do this, one, because we have five new Commissioners, and I want to make sure that people understand fully the context for our past work on SGR, but also because there has been some misunderstanding about our position in the broader discourse about Medicare policy.

One of the very first recommendations that MedPAC made after I became Chairman was, in fact, to repeal SGR. This was in 2001. At that point we predicted that a system that linked unit price to volume of services and total cost was unlikely to be successful in controlling total cost, and in the process could well lead to some serious inequities and, in fact, probably have some unintended consequences.

I have missed on a lot of things that I said during my tenure as Chairman of MedPAC, but I think we were

pretty much on the mark right from the beginning on SGR. It has not succeeded in creating appropriate incentives. In fact, I think it has created some perverse incentives, and for sure it has been inequitable on a geographic basis, on a specialty basis, and most every other basis that I can think of.

So we made that recommendation in 2001. For a variety of reasons, Congress did not choose to act on it. If they had, repealing SGR at that point would have cost next to nothing. In fact, I think if it had been enacted literally when we made it, it would have saved the Medicare program money. But as I say, that didn't happen.

So now fast forward to 2011. In 2011, we decided to take on the issue of the SGR again in an intense, focused sort of way, and there were two sets of reasons for that. One was that it was our assessment, our collective assessment, that the risk to the program from retaining SGR was increasing. The risk in terms of potentially undermining the confidence of both physicians and patients in the Medicare program was increasing.

Second, it seemed to us that repealing SGR was never going to get less expensive than it was at that point

in time. The nature of these things is that the cost of repeal, which has been the barrier to repeal, only escalates over time.

Third was that we could see that savings from Medicare were being taken and applied to other purposes, and many of those savings based in whole or in part on MedPAC recommendations. They were being applied to financing the Affordable Care Act; they were being applied to deficit reduction, both of which may well be worthy purposes, but all the while we were being told, well, we can't repeal SGR because it costs too much, but the potential savings for financing the repeal were being applied to other purposes, leaving this unstable payment system at the heart of the Medicare program. And we figured 2011 it's time to do something about this again.

Coincidentally with that, I testified at a Ways and Means Committee hearing that March on our March report, and members from both parties shared our view that the SGR posed an increasing risk. They said, "Our problem is we can't afford to repeal it because it's too expensive from a budgetary standpoint. Is there anything you can do to help us out?" Again, this was a bipartisan request. So that

spring, we undertook to figure out how we would approach SGR repeal, and we did so with a very, very important constraint that has sometimes been overlooked in the discussion of this.

We undertook our work, which culminated in our October 2011 letter to the Congress, with an important constraint in place, namely, that repeal of SGR had to be fully financed and that it had to be fully financed out of the Medicare program.

Now, we did not recommend, just to be clear, that repeal should be fully financed or that it should be fully financed out of Medicare. That was a constraint that was established for our work. Understandably, and quite appropriately, the Congress is not interested in MedPAC's views about the level of taxation in society or the level of defense spending or other things that might be cut or increased in order to finance SGR repeal. We are the Medicare Payment Advisory Commission so they said, "Tell us how you would do it out of Medicare." And that's the process that produced our October 2011 letter.

If you step back and look at it, the letter said the financing should come roughly two-thirds from a long

series of payment policy changes that would affect everybody from hospitals and health plans to drug companies and nursing homes and home health agencies, and one-third of the cost of repeal, roughly, would come from physicians. And I can't emphasize too strongly, again, this was a constraint that we were working within that repeal would need to be fully financed.

I felt at the time in October 2011 and I feel now, if nothing else, what we accomplished in 2011 was to make it clear what it meant to say SGR needs to be fully financed out of Medicare. It means some very difficult steps would need to be taken if, in fact, that's the course that Congress elects to take. The choice is theirs.

But set aside the financing piece for the second. I think there are three really important messages in our SGR letter of October 2011. One is it is really important to repeal SGR. The risk for maintaining this system grows over time.

Second, we proposed in our package a significant rebalancing of payment between primary care and specialty services. The magnitude of that was influenced by the constraint of fully financing repeal out of Medicare, but if

you set aside exactly the magnitude and the pace, there was clear agreement that we needed to do rebalancing, and two ways of rebalancing were mentioned in the letter. One is separate conversion factors and a second is an intensified effort to examine the appropriateness of the relative value units in the physician pay system.

The third critical message in our October 2011 letter was that if the Congress wants to influence the patterns of care in the Medicare program, the best way to do that is through moving towards new payment models, moving away from fee-for-service to new payment methods like ACOs and others. And we urge them to use this as an opportunity to create an incentive for physicians to migrate over time away from fee-for-service practice and traditional Medicare into new payment methods like risk-based ACOs.

So all of the particulars about the level of the conversion factor cuts, et cetera, were really incidental to the constraint established about it has to be fully financed out of Medicare. But the principles about repeal, rebalance of specialty-primary care payment, a move to new payment systems, I see as fundamental and enduring principles drawn from the Commission's work.

So that's the history of that October 2011 letter, and as was indicated in the presentation, my proposal to the Commission is that we continue to support those principles in our recommendation this year.

So with that preface, let's turn to round one clarifying questions. Alice, do you want to lead off?

DR. COOMBS: Thank you. Slide 4. So the question I have -- and thank you very much for your excellent presentation. I know this is a very complex topic to address. Just in terms of the physician access survey, and I know the questions we saw the slide said that was included in our reading material. One of the concerns I had was that there's this whole component of the physician access survey in terms of how we get our arms around that, and I think it was a 70 percent -- 73 percent in one of the -- I see you have 77 percent here, but somewhere around 70 percent of the time, it was that -- I guess it was not a problem getting an appointment with a physician. And so I know that there are some other components of what it means to actually match provider services with patients' demands in terms of what they need. Have you been able to look at any other kind of instruments?

MS. BLONIARZ: So in the survey, we have questions around did you always have to wait longer than you wanted to see a physician when you thought you should have, you know, questions about when a beneficiary needs a new physician, is it easy or not to find them. We've looked at other surveys, the Medicare current beneficiary survey and the CAHP survey about do beneficiaries -- did they ever not go to the doctor when they thought they should have. And generally, we're finding pretty consistent stuff across all those measures. And I'll also say that Joan conducts focus groups for beneficiaries and for physicians, and generally it's a similar kind of finding, and she conducted those through the summer, spring and summer. There are certain groups that come up with having more access problems, but overall, it seems like the trends are pretty consistent.

DR. COOMBS: So, Kate, thank you much. There's two components of this. We talk about the patients and what they perceive is a problem. One of the things to level the -- in terms of standardizing the questions and how you get at the granular level of is there a problem with access is to actually put a time to it. Did you have to wait longer than eight weeks or four weeks for an appointment? We've

done that in Massachusetts, because that's really important, going to universal health care, and when you get around those questions, then you can see that they're the rate limiting steps for when someone shows in the emergency room because they couldn't get the appointment in a timely fashion, which kind of drives up health care costs.

But on the other side, for the physician piece, and I noticed the last survey was 2011, I think, in the writing material, and that piece is really important, too, in terms of who you survey and what the results are, because you might find that -- in our physician workforce study, we found that in terms of people -- this is for Medicaid, so it's a little different -- that the percentage of acceptance for Medicaid varied from region to region, but there were some as high as 50 percent -- as low as 50 percent and as high as 70 percent. And so that makes a difference, too, because I think there are regional variations for which any of these entities may have differences.

I know that you probably have some information about the physician piece. That's really huge, because you may look at the workforce numbers and they may look -- it may look like a robust workforce, but indeed, when you get

to the granular level, when you get to the number of providers who actually accept Medicare, that's where the rubber meets the road, and especially with a vulnerable population who may be not only on Medicare, but also impoverished, as well.

MS. BLONIARZ: I think there's a couple of surveys that we can look at in terms of -- you'd have some numbers on the providers, number of providers accepting new Medicare patients. I think there are some other questions on some surveys about are you accepting all new Medicare patients. I think, often, you can have situations where one insurance type will be limited, a physician would limit the number.

I think, in terms of the timeliness, it's just the data through 2011 was what we had to report on. In the physician focus groups this summer, I think the findings were relatively consistent, and I talked about that a little in the paper. But that's the only kind of more updated information we have, so --

DR. COOMBS: Thank you.

DR. DEAN: Just to follow up on the same issue, you know, we've seen in other data big variations from region to region, and you sort of alluded to that. Do you

have data that shows how much these numbers, Slide 4, vary from region to region, because I had occasion to speak to a group a few months ago that had people from all over the country and several of them said that it really was a problem for Medicare patients, and in other places, not a problem at all. So --

MS. BLONIARZ: So all we can really do, at the level of -- the number of beneficiaries and privately insured people we're surveying, all we can really do is make large statements about urban versus rural. We don't have any statistical power kind of down to a region level or a State level. It's just because of the sample size of the survey. I know other surveys may have more information. I think the CAHPS is bigger and you can get at more lower geographic levels, but not really in our telephone survey.

DR. DEAN: I mean, I think we've seen in other data that the geographical variation is a more powerful measure -- powerful maybe isn't the right word, but a more significant issue than urban-rural, so --

MR. HACKBARTH: So, let me pick up on that. What we do in this survey is 4,000 Medicare beneficiaries and 4,000 privately insured patients in the age group just

before Medicare eligibility. That's a pretty big sample. Nonetheless, as Kate says, it is not sufficiently large in order to do lots of detailed breakdowns, geographic and otherwise. Even with 4,000 of each, we're limited to some pretty basic cuts in the data.

It is clear that, in fact, access for Medicare beneficiaries varies geographically. These are national average numbers. We have no illusion that it's uniform across the country.

A critical question, though, is to what extent is that variation attributable to Medicare payment rates versus attributable to the dynamics of local health care delivery, for example, imbalances between population and supply or specialty imbalances. There has been research to suggest that the important factor is not Medicare payment rates but what's going on in the local health care market.

So in communities that have experienced rapid population growth, for example, or a significant influx of Medicare-eligible retirees, it is quite possible for there to be imbalances in the supply and demand for health care services, especially for primary care services. But an across-the-board increase in Medicare payment rates would

not alter that supply-demand imbalance. It's an inappropriate tool to deal with the problem.

There has even been research that has looked at the difference between the Medicare payment rate and private payment rates in the market and whether that differential influences access to care for Medicare beneficiaries. Folks at the Centers for Health System Change did that analysis several years ago -- five years ago, I guess it was, roughly, and found that there is not a relationship between the private Medicare payment differential and access for Medicare beneficiaries in given markets. That, too, reinforces the idea that there's lots of differences in access, but it has to do with factors beyond Medicare payment policy that are more fundamental to local population differences and delivery system differences.

DR. DEAN: I understand, and I don't disagree. It's hard to know how that factors into the overall Medicare policy we're trying to deal with. But, no, I accept that the payment is only one factor. But it's still the variation and the lack of access in some areas is still a concern. I guess that's --

MR. HACKBARTH: [Off microphone.] We agree, Tom.

We talked about this before, and the question is always, what do you do about it, and --

DR. DEAN: [Off microphone.] What to do about it.

DR. MARK MILLER: Well, and just on that last point, because I thought you were going to also add to that, was in the conversation we had a month or so ago in talking about the floor. We also said to ourselves, if we think that there are policies where you target, and when you think you have a supply or an access issue, then we should start thinking about that. And some of the same crew sitting up there will be thinking about that for the spring.

DR. DEAN: [Off microphone.] Okay.

DR. CHERNEW: I agree with everything that Glenn said, but I -- I believe Glenn would agree with what I'm about to say -- that doesn't mean extreme changes in payment wouldn't have effects on access. That means within the range of the stuff that we've seen, we haven't seen a lot, and we recognize we're always backward-looking. But some of the extreme changes in payment that one might think about certainly could have it. So I don't think you meant to imply that physician payment or Medicare payment doesn't affect access.

MR. HACKBARTH: Yeah. Yeah. Thanks. So if the SGR cut were to go into effect, 27 percent, and that were to stay in place for any extended period of time, I would be surprised, personally, if that didn't have an effect on access for Medicare beneficiaries. But within the range, the narrow range of update factors, I don't think that those are powerful tools.

Cori.

MS. UCCELLO: A couple more access-related questions. I think I've asked this in the past, and there may just not be the sample size for it, but with respect to minority beneficiaries having more difficulty accessing specialty care, do we know if they are also more likely to not have a regular source of care?

MS. BLONIARZ: I don't know that we know. We could think about it.

MS. UCCELLO: Because I thought before that there was a question that we could get at that, but I was just assuming that when you start slicing it that much, you might not be able to get at it. But if you can just look into that, that would be good.

Also, just generally, people have less problem

finding a specialist than they do a primary care physician when they are looking for one. However, in the provider focus groups, it said that specialists were more likely to not take certain insurance. And so is this a Medicaid issue or --

MS. BLONIARZ: I think --

MS. UCCELLO: I'm trying to figure out if this is contradictory or if this is just answering kind of a different question.

MS. BLONIARZ: I think -- my understanding of what the focus group finding was is that there are some specialists that will not take Medicaid, will not take certain HMOs, Medicare Advantage plans, that those provider network restrictions just might be tighter. But I'll defer to others.

MS. UCCELLO: Okay. So it's not necessarily contradicting the bene survey.

MS. BLONIARZ: Right.

MS. UCCELLO: And finally, do we know -- and maybe it was in the chapter -- do we know what share of ASC payments come from Medicare?

MR. WINTER: There is an MGMA survey of ASCs which

estimated that 17 percent of the ASC revenue is from Medicare.

MS. UCCELLO: Okay. So this just gets to the --

MR. WINTER: That's three years old, so --

MS. UCCELLO: -- if this is certain beneficiaries or certain people in general don't have as much access. I'm trying to get a better sense of how, you know, is this a Medicare problem or a general problem, and it seems like it's not specific to Medicare.

And along those lines, in past years, for the December meeting, or maybe it was January, we would get a sheet that would show the different services -- it would have a pie chart of total Medicare spending and what part goes to the different services. I think having something like that again would be useful, as well as if we could have for each service type just that summary of what share of spending for that service comes from Medicare.

MR. HACKBARTH: I think we can draw that from the context chapter, can't we, Jim?

MS. UCCELLO: Is that -- okay.

MR. HACKBARTH: Yeah. Herb.

MR. KUHN: First, let me start out by thanking

Glenn for that overview at the beginning and really kind of walking everybody through the road map of where we've been and where we are now to put it in context. I think that was very helpful and a good refresh and a chance to level set for everybody where we are.

I'm going to follow the same pattern as others here and ask a question about access to physician services. Last year, when we looked at the survey information, the data that showed that the share of beneficiaries who were looking for a new primary care doctor reported a very big problem. And when we looked at the data last year, and I think there was kind of a collective intake of breath by a lot of folks that, okay, is this now the new tipping point that we're starting to see here? Are we finally starting to see the fatigue of physicians and they're saying, we're not going to take Medicare beneficiaries anymore? Or was it a statistical wobble and is this something that we would see change the next year?

Well, obviously, we have the data this year and it looks like the data has returned to the 2009 and the 2010 levels from where we are, so I guess I'm just curious, your thoughts in terms of that blip we saw last year with the

real difficulty people were having in finding a new primary care doctor. Do we think it was just a wobble or do we think that's a trend of continuing potential access problems in the future? Or do we also believe that it's possible that now as more hospitals are hiring physicians, is that creating better access in certain areas of the country as we go forward?

I don't know. I'm just trying to think back to that conversation we had last year, because it was startling information when we saw it.

DR. MARK MILLER: There was some internal conversation about this. It's always important to remember that these are small numbers, and so even when it went up, we were saying, be careful. And now that it's gone down, I think we're saying, be careful.

The other thing to keep in mind is what also moves, although it's not so much, is what percentage are looking. And so I think when Glenn and I were talking about this yesterday, if you kind of do the math between who's looking and whether they have a big problem or not, and you look back four or five years, it's not all that different. So even though it's moved around in that five years, it's

not all that different.

And so I think Glenn, when we were having the conversation, was saying -- and you're free to express your own opinion here at any point -- you know, I see this as still a concern that I have that the same, roughly the same percentage of people are having trouble finding a new primary care physician as we've seen, say, five years ago.

DR. COOMBS: Mark, I just want to ask, what's the margin of error with the numbers we're seeing right now?

DR. MARK MILLER: Well, I mean, I'm -- not necessarily can answer it that way, but there is very few statistically significant differences from year to year, which is --

MR. HACKBARTH: Yeah. So this is a pretty big survey, with 4,000 people, but it's important to keep in mind when we look at this particular set of statistics that what we're doing is sampling a fraction of that 4,000. So these are people who say, yes, I'm actively looking for a primary care physician, which is only six or seven percent of the 4,000 total. So the sample has gone way down. And then we ask them to characterize -- that six or seven percent to characterize whether they had no problem, a small

problem, or a big problem. And so now we're talking about a much smaller number and a number that, just from a statistical standpoint, I think, is more prone to jumping around.

You know, my own take on this, since Mark invited me to offer it --

DR. MARK MILLER: Well, I was trying to say it so you didn't have to.

MR. HACKBARTH: Yeah. I was really worried, like I think you were, Herb, that the numbers last year, a very, very large jump in people saying they were having a big problem finding a new primary care physician. I was pleasantly surprised to see that the numbers had gone down and were more similar to previous years.

Having said that, it does not relieve completely my concern about where we are and where we're headed. My fear is that we'll have various factors interacting with one another that might create a precipitous increase in problems for Medicare beneficiaries. So, for example, we've got a lot of physicians, including a lot of primary care physicians, who are now nearing retirement age. We've got a small but growing number who are saying, well, I want to go

into something like concierge practice. You know, we've got this instability in policy and payment rates.

My fear is that, in relatively short order in some markets, to go back to Tom's point, we could find a significant number of physicians saying, you know, I've had it up to here with this annual ordeal about SGR and uncertainty. I'm near retirement. I'm just not taking any new Medicare patients. And you're aware the Medicare population is starting to grow rapidly, and for a combination of factors, we could see a precipitous drop in access.

That's why I think it's urgent to do what we can to stabilize the environment, and repeal of SGR, I think, is a critical component of that.

DR. SAMITT: Can I just comment quickly? I think we need to be very careful about the statistics that patients are not having problems getting access to PCPs. I may be just one organization's perspective, but my sense is that other organizations are experiencing the same. In the last two to three years, we have seen a significant diminution in the utilization of services per individual and it's very much related to economic effects, that folks are

going to see physicians less often, which has resulted in a very positive explosion of accessibility within our organization on a fixed complement of physicians. So panels are reopening. Physicians are concerned that they're seeing a diminution in volume. They're accepting more patients.

So the question is, is could this be even an economic effect that is creating a temporary accessibility, which when the economy recovers, we may see the pendulum swing again. So I'd be very cautious about what this would suggest. I'd be worried that it could swing again next year.

DR. NAYLOR: I would agree with that. And, of course, with the growth in the Medicare program itself, of the number of people who are going to need to access these services over the next couple years. But I think -- and I totally support all of the recommendations related to SGR for all the reasons that you have articulated. But I do think some of the data that you presented about the growth in other primary care providers, 2.3 to 2.6 per 1,000 beneficiaries of nurse practitioners and physicians assistants and so on, are also other factors that we can watch to balance what might be happening in terms of primary

care access going forward.

[Off record discussion.]

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

MR. BUTLER: The recommendation on the ASC calls for asking for cost data. Last year, we recommended value-based purchasing be put in in 2016, so this year we're adding on to the recommendation cost data, which I guess CMS has started to ask how that might be done.

What I'm a little less clear on is what -- this is just such a general -- are we looking so that we can estimate increases in the market basket? Are we trying to demonstrate that it's cheaper? Which we will because you'll see repetitive, more easily done -- what are we going to do with the -- other than have the cost data, what specific answer do you think -- or problem are we trying to solve once we get this in our hands? And the second part of it is obviously the cost of -- you said there are some costs associated with collecting the data. We just need to think about that.

MR. WINTER: Actually for the last four March reports, we recommended that ASCs submit cost data,

including last year, and it's for two reasons. One is to get data on costs so we can calculate margins and use that as an input. You could use that as an input into your decisions about the payment update for the future years. This is one of the few sectors where we don't have cost data to calculate a margin. And the other reason is so we can -- we, CMS, can figure out what's an appropriate input price index for ASCs, because currently they use the CPI. They've been using it for pretty much their entire existence in Medicare, and it's sort of a default price index. And it represents buying patterns in the general economy, not, you know, patterns of inputs for a health care provider.

And so about two years ago, we did try to look at whether an existing input price index in Medicare, like the hospital market basket or the practice expense component of the MEI, would be a better proxy for ASC costs than the CPI, and we found in some ways ASCs have a different cost structure than hospitals and physician offices. We were using pretty old cost data that had been collected by GAO in 2005. So, you know, it wasn't really ideal for creating a new price index or even accurately measuring ASCs' cost structure. But it did provide some indication that their

cost structure is different, and, therefore, CMS should collect cost data, more recent cost data, and in sufficient detail so that they can figure out whether an existing price index, like the hospital market basket, is a good proxy or whether a new one should be created. And this would be a factor that the Commission could consider in making a recommendation for an update as part of its process.

MR. BUTLER: So, just to follow up, I'm still a little unclear. You mentioned margins. Well, cost data won't give you margins. All it will give you is the cost side of the equation. So I know we discussed this before and said if it's a full cost report, that's expensive. Maybe it's an audited P&L. I'm just trying to picture in my mind what the range of cost data might look like if we're going to ask that it be submitted.

MR. WINTER: So we have talked about two options for that. One would be a targeted random -- a survey based on the random sample of ASCs with a mandatory response rate, and CMS has conducted these surveys, cost surveys of ASCs twice in the past. Or we could think about a streamlined cost report that every ASC would have to fill out. It would be more streamlined than the hospital cost report, so

perhaps more akin to a cost report filled out by smaller providers, like hospices or home health agencies. But we have not gotten into the level of detail in terms of, you know, what specific -- you know, what categories should they be reporting and how should they be reporting them.

DR. NERENZ: The data on access is important and reflects one particular behavioral response on the part of physicians to potentially inadequate payment, and that would be to refuse to see new patients or hold off access to old patients. Clearly, though, there are other responses, so, for example, in the face of inadequate payment, the physician can spend less time with a patient, coupled perhaps with seeing more patients, ordering more tests; could spend less time off-line talking to family, less time doing care coordination, et cetera.

Other than anecdote, do we know about those other responses? And have you had any chance to try to examine those as part of this context?

MS. BLONIARZ: The only thing I could say is just from the focus groups, where a few number of responses said that those kinds of things were used to -- it seemed like that providers were using those kinds of things to limit the

number of Medicare patients in their panel. But that's the only kind of piece of information that I have.

DR. MARK MILLER: The other thing that occurs to me, Kevin, is that in the volume data you would know what level of time visit -- not off the top of your head, I'm sure, because I would be very impressed, but, you know, we might be able to look at sort of the coding pattern and, you know, 15-minute visits, 20-minute visits, that kind of deal. Am I way off base, Kevin?

DR. HAYES: No, and there is, you know, a table --

[Laughter.]

DR. HAYES: There is a Table 4 in the mailing materials that talks about how the intensity of coding for visit services has gone up over time. And if you happen to be looking at Table 4 on page 20, if you look at that line that says office visits and look down at the number for units of service 2010 to 2011, it's 0.6. And then go over to that similar number but for change in the volume of services of 1.8 for 2010 to 2011, for that same category of services, are you with me? All right. That difference represents a difference in coding intensity. The difference between 0.6 and 1.8 represents a difference in coding

intensity for those visits. Okay?

DR. MARK MILLER: Or in other words, coding for longer visits.

DR. HAYES: That's right. That's right.

Now, then the question is: Well, is that just a coding change? Or is that an actual change in the duration of visits?

The only way I know of to actually get at data on the length of visits, what gives us just the face-to-face time is the National Ambulatory Medical Care Survey, which does have data on this. And the research that has been done with those data, I don't recall that it's anything specific to the Medicare population. It was just overall that those numbers have been remarkably stable over the years, the duration of -- the amount of face-to-face time during office visits has been pretty stable. But we could conceivably look at that, you know, differentiating Medicare from others, if that's what you're thinking about.

DR. NERENZ: Yeah, and that would be one example, and actually in my hypothesis, it could have run the other way, meaning a physician might find it advantageous to see and bill two 15-minute visits rather than one 30, and then

have the patient come back again. The point is it would be complex, and I think what would be even harder to get data on than this would be some of the off-line activities like the general class of care coordination for which there is not a bill submitted and there's no real direct recording, but conceivably would be a response to a sense of inadequate payment, just I will spend less time on the phone. So I'm just curious what we know.

MR. HACKBARTH: We can take a look at that. I think it's going to be challenging. There's certainly a lot of anecdotal discussion of the phenomenon you describe where people are responding in various ways.

DR. SAMITT: Slide 16, please. Assuming great optimism regarding the Chairman's recommendation regard SGR, I'm interested in bullet number 3, and I would imagine we haven't done this modeling, but I would be interested in it, which is: What is the incentive today versus the baseline for organizations to move to ACOs? Because I think this would be a very telling factor, especially if the SGR is repealed. I would imagine we would want a significant incentive between a fee-for-service repealed SGR baseline and a movement toward a value-based care delivery model. So

I don't know if that information exists today, and I probably should know the answer as an ACO. But I'm not sure that we've looked at it to that degree.

MS. BLONIARZ: Well, one thing we could just do is kind of describe, I think, how the recommendation would work. Essentially, under the recommendation, the shared savings baseline would not incorporate the specialty cuts that are kind of part of the fourth bullet, the cuts in payments for specialists that was conceived of. And so that would be kind of an incentive for specialists and other providers to be part of the shared savings program because the baseline would be higher.

DR. SAMITT: Fair enough.

MR. GEORGE MILLER: Yes, some of these are statements, so maybe I should wait until --

MR. HACKBARTH: Clarifying questions [off microphone].

MR. GEORGE MILLER: Yes. You clarified the clarifying question. I'll wait until Round 2 then.

DR. HALL: We'll get back to you. Don't call us.

[Laughter.]

MR. GEORGE MILLER: It's got to come back around.

DR. HALL: I think the statistics on access are kind of a tribute both to the Medicare system and to the care providers in this country. They're very good. But as we go forward -- or maybe you know the answer to this already. I think there are two populations that need to be watched carefully among Medicare recipients. One are people who migrate, typically retire, move somewhere. Usually they're in a southerly or westerly direction. I think a lot of people don't move to New Jersey and places like that -- or New York, rather. And many times they seem to be having a lot more trouble. At least that's what the anecdotal story said that I get, particularly if they are disinclined or there is not an available Medicare Advantage program. I think there's a lot of stories about that. So even though the number -- the absolute number may be very small, in the aggregate, for those people it could be as much as 75 percent of the people can't get a care provider for a significant period of time.

The other is, as various corporate structures start to reorganize in the United States, there are many that have very good benefits for their employees post-retirement. In my own community, I'm seeing that where a

major employer has now gone bankrupt and has just announced with 30 days' notice that the retirement health benefits are gone. So this means that, yes, they do have Medicare, but they're going to have a hard time getting into the system now. Again, they're not going to have quite the choice that they thought they had, and so I think we may -- let's look forward for -- as the economy moves in unpredictable directions, make sure that that 13 percent, or whatever it is -- and, in fact, maybe it's much higher if you happen to fall into that category.

Thank you.

DR. NAYLOR: Can you remind me, on the Medicare ambulatory care indicators, beyond the few that have to do with health resource utilization, have we made any recommendations about moving from multiple process measures to something that would be more relevant to the Medicare beneficiary, their outcomes?

MS. BLONIARZ: So the list of the measures are at the end of the paper.

DR. NAYLOR: Right.

MS. BLONIARZ: And most of them are kind of process measures except for the avoidable hospitalizations,

the avoidable complications measures, and, you know, I'm not sure where that stands in terms of --

DR. NAYLOR: But the Commission hasn't made any recommendations about advances in those measures?

MS. BLONIARZ: Not that I'm aware of.

DR. NAYLOR: Okay.

MS. BLONIARZ: The one thing I will say is I did look up just how they stack up to kind of current task force recommendations and other clinical bodies that have made recommendations on kind of standards of care, and they still seem pretty consistent, even though they're process measures.

DR. NAYLOR: My second question is: Last year in the report, we had a really good sense of the 300,000 of 850,000 physicians and other health professionals, the 300,000 that are not physicians, of how much they were contributing to primary care. I recall a third were either the primary source of primary care or on the group of providers. So do we have a sense from this work now about the contribution of other health professionals to the primary care?

MS. BLONIARZ: We have some stuff from the survey

that we can add about whether you see -- whether the beneficiary sees an advanced practice nurse for, you know, some, all, most of their care, and we can add that in.

DR. NAYLOR: Thank you.

DR. HOADLEY: I have an observation, which I don't know if it's clarifying, but -- and then one question. You know, listening to this discussion of access, and particularly the geographic pockets kind of argument, makes me reflect on the fact that, you know, almost 20 years ago, when PPRC was looking at these same questions, and I was staff then, it felt like we were having the same conversation we're having today. You know, access doesn't seem like it's very good. All the surveys say it is good. We took up in those days various, we thought, creative ways of trying to look at the geographic pockets and would generally find there wasn't much there except beyond the anecdotes and always worried about it. So, I mean, this is something that this Commission and its predecessor have been looking at for a long, long time.

My question is much more narrow, which is -- and this is more from the reading materials, but on the ASCs, there's obviously this very extensive geographic -- I don't

know, not disparity but, I mean, differences in where the ASCs are located. Do we know anything really about how that has come to be? Is some of that certificate of need? Are some of those other historical tradition?

DR. ZABINSKI: Ariel can add as well to this, but I think part of it is certificate of need. It definitely seems like the CON states have fewer of them than the non-CON states.

Anything to add to that?

MR. WINTER: Yeah, I guess it could also relate to demand for these services by the commercially insured population since that's where most of the revenue is from. Only 17 percent or so is Medicare. So it could be a factor of, you know, what demand is in the non-Medicare population.

DR. MARK MILLER: If I could do one quick commercial -- and just for the new folks -- when we do the focus groups, sometimes the criteria has been driven by going to places where we think there is a problem in order to supplement the national survey and see what we find there, and that's another -- that's similar to what I guess Jack was doing as a staff person at PPRC, and we're still looking at this problem.

MR. ARMSTRONG: I think that's what this is. So in the last few years -- this is the ASCs -- we saw rapid growth in ASCs. Payment policy changes and other things have actually shifted the growth patterns. It's now the hospital-based surgical procedures that are growing so quickly, and ASCs are kind of flat in terms of their volumes.

But we know we're paying significantly more for the hospital-based services, and I guess my question is: What if we increased significantly the payments for ASCs? Do we think that that could sort of bring the volume back out into them?

DR. MARK MILLER: Or lowered the payments to OPDs?

[Laughter.]

DR. MARK MILLER: Just as long as we have two sides of the conversation.

MR. ARMSTRONG: We're trying that, too, right?

DR. MARK MILLER: It's in discussion.

I don't know. I mean, do you guys have any instinct whether a rate change like that would change the direction? And I guess some of this turns on whether we see lower use, like we see generally lower use in the last few

years, or whether things are moving from the ASC to the OPD and that drives part of it?

DR. ZABINSKI: Well, on that last statement, we looked a little bit into whether there's movement from the ASC to OPD, and it doesn't really look like it. We examined the top 22 provided services, and they account for 70 percent of all Medicare ASC volume, and none of those really said that there's movement. You know, it wasn't any situations where the OPD volume went up and the ASC volume went down, for example.

MR. ARMSTRONG: So it's just going up all over the place.

DR. ZABINSKI: Well, I would say, you know, we do see higher growth in the OPD right now than what you see in the ASC. But my guess is that's probably more from services moving from the physician office to the OPD rather than from the ASC to the OPD.

MR. ARMSTRONG: Okay.

DR. ZABINSKI: I'll stick my neck out a little bit. If you raise the ASC rates, yeah, I would think the ASC volume would go back up.

MR. ARMSTRONG: Okay. But we have no way of

knowing whether the OPD volume would go down?

DR. ZABINSKI: I don't know, no.

MR. ARMSTRONG: Okay.

DR. MARK MILLER: From the physician's office -- and you're correct in your first statement, then probably not. And then also, I mean, at some point markets -- there was a lot of growth. At some point markets start to get saturated, so you've got to anticipate that there is some slowdown.

MR. HACKBARTH: Round 2. In this case, as I said at the outset, we're not voting on a new recommendation. So, you know, think of the task in Round 2 here just to offer ideas, comments that you would like to see included in our discussion of these issues in the report.

MR. ARMSTRONG: Glenn, just to clarify, isn't the ASC rate a new recommendation?

MR. HACKBARTH: Yes, actually, thanks, Scott, for pointing that out. So we do have the ASC recommendation on which we will have a vote in January. So I would like to know where you stand on that one in particular. Thank you, Scott.

DR. COOMBS: So on the ASC, I know we talked about

quality, but can that be added to that recommendation as well? Because they were talking about the difficulty with getting data. Is it possible?

MR. HACKBARTH: Say more, Alice, what you would like included in the recommendation.

DR. COOMBS: Cost data and quality data as well.

MR. WINTER: They have already started to submit quality data on five measures. What does not exist is a value-based purchasing program that would adjust their payments based on their actual quality performance on those measures.

DR. COOMBS: Right.

MR. WINTER: CMS does not have the authority to even create that kind of program. Our recommendation last year was that Congress should give the Secretary the authority and direct her to create this program.

DR. COOMBS: Okay.

MR. WINTER: Is that what you're suggesting?

DR. COOMBS: Right, right.

MR. WINTER: Okay.

MR. HACKBARTH: So you'd like to see that added to this recommendation, that the Congress direct the Secretary

to do a value-based --

DR. COOMBS: Right. And I support it.

MR. HACKBARTH: Okay.

DR. COOMBS: On the first one, in terms of the SGR, I think Craig said something that was so poignant to me, and that is that the fact that you have offices within increasing vacancies in terms of availability of appointments is an issue in some sectors, in some areas. The patient benefit design in terms of the co-pay in and of itself has been a deterrent for some patients to actually come into the office. In one of the regions of Massachusetts, one of the physicians said that patients who normally would come in the office would say things like, "Can you call me in a prescription for X drug over the phone? And if I don't get better, then I'll come in to see you." And so there was this distant relationship rather than coming in and having a full examination. So that's always an issue.

I have to say that in terms of access, I think it really is a tyrosine hydroxylase and the whole synthesis of dopamine here. And one of the things that I look at is if you start with the lowest requirement, it's access, it's

access, and I think that for -- in other words, it's the rate-limiting step. That's what I mean by tyrosine hydroxylase. In that for us to look at access in a very, very microscopic fashion to the point where we can actually say that something is either enhanced or not enhanced is one of the charges that this Commission has.

You know, recently, I have spoken with -- and I shared this with some of the group earlier -- a urologist group that said if the SGR goes into effect, 50 percent of our patients right now are Medicare patients; what we will do is we'll have eight slots for our regular patients and we'll have two slots for Medicare. Well, has access gone away? No. It just means that there's going to be a delay in those patients getting into the office in a timely fashion. And we know that timely care is really important because the delay of onset -- diagnosis and the onset of illness can actually result in worse complications or worsening disease processes.

So I think that the way we look at access is not just by saying do you have a problem, and that part of the problem is when you have a patient on the other side that doesn't really know when they have a problem because of

health care literacy concerns, and so I think it's -- the access issues is so complex that, you know, before we walk away from the table and say we don't have an access problem -- and the point I brought up about the margin of error, if you get a 75 percent concordance that you don't have problems with access, and you have a large margin of error and a small sample size, it's possible that it could be that 50 percent of the people actually have a problem. And you just had this rare sample size that actually is a little divergent from the general population. Is it extrapolated to the general population of Medicare patients?

MR. HACKBARTH: So it's clear that, as you say, access is a really complicated phenomenon. It's clear that it is variable geographically and probably by specialty as well. What I'm not clear on -- and it's also clear to me that we shouldn't be glib in saying there is no problem.

DR. COOMBS: Exactly

MR. HACKBARTH: And as I said earlier in the context of SGR, I really fear that we could develop some big problems quickly, and so I don't feel at all complacent about access. And I think you and I agree on each of those points.

What isn't clear to me, Alice, is what measures you would like to see, and so let me stop there.

DR. COOMBS: So some of the points that have been highlighted already -- and you've done a super select sample of -- as Mark has said, I think you looked at areas where you thought might have been problems in your survey.

MR. HACKBARTH: Right.

DR. COOMBS: And so I would actually go back and do a much more clarifying survey about actual time -- time to see doctors. And I don't know if that's possible, but that's the kind of information that you really want about access. Not a yes-no, not, oh, a little, small problem, somewhat, or that kind of thing. I think that you kind of want to know, well, does it take you eight weeks to see a doctor? It may be okay for patients to say, "That's not a problem for me. I can wait eight weeks," when indeed maybe eight weeks is too long.

DR. BAICKER: Just a point on that question. I know it would be very labor-intensive to do another survey or to modify this survey going forward. There are a number of other surveys that ask questions like that of different sets of people where you couldn't do direct links and you

couldn't necessarily break down the same populations, but maybe you could see if they're measured in enough geographic -- fine enough geographic detail, you could see do the measures that you're using here correlate reasonably well with some of those other measures to get a sense of whether you're -- you know, almost a factor analysis. Are you pulling out something real? Or are there important components of true access that aren't captured very well by these measures? And I think we would all have a sense of security in our measures of access if there were reasonable concordance across these different modes of asking, because there are surveys that ask about how long does it take you to get an appointment, and plan performance surveys that say are you satisfied with the quality of information you're getting from your provider or the quality of time you're spending with your provider, and those might capture the more nuanced sense that we're all looking for.

MR. HACKBARTH: So, in the interest of time, I think I understand that, and let's maybe have a conversation here and pursue this angle of looking at whether -- other sources of data that may shed light.

DR. COOMBS: And I appreciate, Glenn, the fact

that we're all around this table, I think everyone is concerned about this, but to get our arms around what really is good access versus complicated and compromised access, I think, is the bottom line to how we go and how we navigate through this SGR process.

MR. HACKBARTH: Tom, round two.

DR. DEAN: I certainly support the SGR recommendations. I just wish there was a way to make the SGR recommendations more immediate in the eyes of Congress and to somehow convince them this really is a ticking time bomb, because I think it's only going to get worse, and at some point, we're really going to see a disaster from this. But I think we've tried and we keep trying, I guess. So, anyway, I support that and also the ASC recommendations.

MR. HACKBARTH: Cori, can I just say one thing in response to Tom? So one possible reason that Congress has not moved to repeal SGR is the budget problem, and I think that's a really big one. I don't know what else we can do on that front.

DR. DEAN: [Off microphone.] Right.

MR. HACKBARTH: A second reason is that they don't share our sense of urgency about this. They don't see the

potential for this unraveling quickly. I'm not sure what to do on that and I'm open to suggestions for how we can save that in a way that makes it more compelling.

A third potential reason is that people believe that, well, if we do another short-term fix, you know, say two years, in two years, we will have a solution that won't be painful for dealing with the budget problem and we'll have a better physician payment system and we can just move people in two years from now. People have been saying that sequentially for year after year after year. I believe that's a false premise, myself. I don't think there is a painless solution to the budget problem.

I think in terms of new payment models, we've got one up and running now with ACOs. Now is the time to begin moving -- creating incentives for people to move in that direction. I don't think -- in two years, we may have added bundling around a hospital admission or a couple other wrinkles, but the picture will not be dramatically different in two years in terms of new payment options than it is today. And to keep pushing this out into the future and to hope that some new solution is going to materialize, I think is mistaken. Maybe we can be more forceful in how we make

that point.

DR. DEAN: I guess that's just what I was alluding to. If there is any way to state this in even stronger terms than we already have, I would strongly support doing it, whether it's bold print or whatever.

MS. UCCELLO: I agree, and I agree it's kind of difficult to figure out how to stress this more. But people said earlier, and Mike might say it again now, but also, just kind of highlighting, again, that these options that we came up with were difficult. And if their intention -- if Congress's intention is to really do this by paying for it through other Medicare reductions, then stressing again how they can't pick things off this list and use it for something else, because that's going to make this even more difficult. So just, you know, if we can stress that again.

So I strongly support including this again, stressing it as much as we can, and also, I think that ASC recommendation is reasonable.

MR. KUHN: I'm good with rerunning the SGR recommendation from a year ago. I think that makes sense.

Also, I'm fine with the ASC recommendation, and I do appreciate, Kate and everybody else, all the good work on

this particular chapter, or both chapters, this and the physician and ASC chapter, and particularly all the good work on the access. I think we had a very good discussion on that today and really good discussion in the papers. Thank you for that.

DR. CHERNEW: So I want to, first, add my voice to the general message of SGR first, meaning when we find money to save, use it to fix the SGR and then we can think about other things you might want to use it for. And I think, you know, the money is fungible, but I think we really have to support the message that the SGR has to go away, and I agree with that.

I want to talk more about the other issues, ASCs and such, and one of the challenges we have is -- which we know -- is there's all of these separate services and site of care can differ. We've had a lot of long discussions about site of care-type things. And I think it's stunning how little we know about the substitutability across the services and in particular how that substitution would change in response to things we would do.

So even though we can see trends moving one way or another, there's trends and associations and there's causal

things. If we change an update for ASCs, you have to think about that with regards to the other sites where similar services could be provided, and we have updates for those and how do we keep it consistent. And even if the updates are moving differently, they're starting at different levels. So a model of where care would go and where care should go is conceptually hard, but we don't have to do that because we don't have the data to fill it out anyway.

So we're sort of left with dark in this sort of complicated way, and I think that matters, but it's relevant to the comment that I'm going to make which relates to the ASC recommendation.

So I support the ASC recommendation, not with huge enthusiasm or not, but I support it because of this notion that we have other things that are moving up a little more that might be substitutes in how we're going to do it. But there's other things that might be moving up less overall. I think if it was ASCs alone, without the cost data -- my personal opinion is, without the cost data and the evidence that we have on the table, it strikes me that there's other services that we have given lower update rates to than ASCs, and I don't see that there's a problem in access to ASCs or

some of the other capital things. But there's a notion of how we set that rate relative to other similar services and I don't know how to deal with that.

So the end of this rambling point is, I support where we are within a wide range of uncertainty, but I can be convinced to support less generous updates if I were looking at just ASCs alone.

MR. BUTLER: I'll start with the ASC recommendation and say I can support it. I would like us to be as precise as we can about the cost information so that it's as useful a recommendation as we can make it.

But a couple comments on this. I know where George is going to go with this, but -- so I won't trump you, I promise. In looking over the last 25 years or so, I think the movement to ASCs has been primarily physician-led for two reasons. One, they had ownership. And second, time is money, and to the extent that you had efficient operations for the routine stuff, they said, this simplifies my life. And so what do you think we have in those even today? It's mostly, if you look at the lists, it's the interoccular lens, it's the pain, nerve injections, and it's the simple ortho stuff, and it's pretty much stayed that

way.

So when you think about that -- and it's only -- only three -- $3 billion. This isn't a huge industry unto itself for the Medicare. If you look at what's happening on the hospital outpatient stuff, you'd be surprised the number of stuff that is flipping minimally invasive and becoming overnight or close to it that really would be a whole different kettle of fish than what we're talking about that's in the ASC bucket right now. And that -- a lot of that stuff will need to be in the hospital because you want to say, okay, do I need to observe this or not, but you will be flipping, actually, from an inpatient to an outpatient payment within the hospital setting, which has savings by itself.

So this isn't quite as clear as it sounds when we just present the list of things that are sitting in ASCs today.

MR. HACKBARTH: So what I hear you saying, Peter, is that given trends in the delivery of care, that the substitutability of ASC for HOPD for surgery may be less in the future than it's been in the past.

MR. BUTLER: Yes. If we wanted to pursue a same

site kind of thing and you really did it -- it would work best if you did just take, okay, fine. We'll take the eye procedures, the nerve injections, and we'll take the colonoscopies, endoscopies, the stuff that you could kind of limit it to a --

MR. HACKBARTH: Right.

MR. BUTLER: -- non-debatable list of things that says, you know what? You might save and you could -- and there's no way you really need the hospital oversight for those kinds of things and zero in on a set rather than blanket let's just narrow the difference between the two, because it wouldn't make sense for some of the things. But you could for a short list. This isn't unlike our other discussion on same site kinds of things.

Back on the SGR. There's been kind of a quiet, less discussion around this than I anticipated in many ways. But just so I'm clear in my mind, we kind of have up there the Chairman's proposal is to restate the SGR. I don't know what that means. We're not voting on anything. So we're kind of talking about it, but we're kind of silent in terms of any official vote on where we stand --

MR. HACKBARTH: That's right --

MR. BUTLER: -- because we've already submitted the letter.

MR. HACKBARTH: Right. And so we would note the letter, or summarize the letter, or include the letter -- not an appendix, because it's too long, I think, to do that -- but we'd summarize the letter and then in the text we would make the points that we're discussing now about the urgency, et cetera, and the thinking that was behind the letter.

MR. BUTLER: Just, in my mind, it's a little fuzzy if I'm following this session and then the one in January and say, what did they do with physician updates? By the time they really get it, it's kind of, like, March, and -- oh, yeah, we have that letter that we -- and we cited it at that point in time. It's a little less direct than kind of saying we're restating the letter. I'm not suggesting we re-vote on it, but it kind of is a little indirect way of kind of saying where we sit. I'm not sure of the answer to it, but I know people want to know sooner rather than later where we stand and --

DR. MARK MILLER: And just so you know -- and I think you know this, but I'll just say it out loud -- you

know, despite the fact that it actually gets printed and published and sent out in March, and there may be people at that point who read it and go, oh, that's what they did, the immediate client, the committees of oversight, they know immediately what our decisions are in January. And so you shouldn't think that, somehow, it doesn't get communicated to them.

MR. BUTLER: But we don't have an official decision around this in terms of we voted on it.

DR. MARK MILLER: I understand what you're saying, but come January -- or depending on how this conversation terminates and January's decision terminates, we can go to the Hill and say, okay, our policy is what it's been, and you have this letter. Here is the letter again. You can make those kinds of transactions with them. But you should already know that the committees of jurisdiction know what this conversation is and what is being discussed today and how we're approaching it. So those people do follow what's going on.

So, for example, I briefed them before all of these meetings and I'll say, the discussion that the Commissioners are going to have tomorrow is this discussion

-- I won't describe it, you're part of it. And I'll say, so if you're thinking one year or four months, that's not where the Commission is. The Commission continues to say, this is the way you should approach things. You should repeal the SGR. So they know that we're -- I mean, assuming the outcome of this conversation, we're potentially in a different position than a one-year fix or whatever the case may be.

But you don't seem like that was the answer to your question.

MR. BUTLER: No, the people -- you're saying the people that need to know, because they follow this, and you don't have to -- I'm just trying to think if you report in the New York Times, the Commissioners voted on the following recommendations in January, boom, boom, boom, boom, boom, there wouldn't be anything listed at all for SGR. Or physician updates.

DR. MARK MILLER: And Robert Pear is here, so he knows now, so -- we got him.

[Laughter.]

DR. MARK MILLER: I see your point, the general point.

DR. COOMBS: Glenn, just a point of information. After Peter said that, it kind of jarred me. So you wanted us to state whether or not we supported all of the bullets that are in the SGR on this slide, is that correct?

MR. HACKBARTH: [Off microphone.] You're welcome to.

DR. COOMBS: Okay. So now that Peter kind of jarred me up here a little bit -- thank you, Peter -- I do support the first three bullets. The last bullet, I have a problem with, and I just want to go on record for that, now that I know that there is some kind of official stance that we have to take. Thank you.

MR. HACKBARTH: Let me reiterate what the last one is. That is not what MedPAC is recommending. The operative word there is "if." If Congress decides that it, A, needs to be fully financed, and B, it needs to come from Medicare, this is a series of options for them to look at to do that. We neither advocated that it be fully financed nor advocated that it be fully financed from Medicare. I want that to be crystal clear.

And so the really important part of the letter, as I said, the MedPAC policy point of the letter is repeal,

rebalance primary care versus specialty, create incentives to move into new payment systems. All of the rest is stylized to answer the question, if Congress says it needs to be fully financed under Medicare, what are their options for doing that. So nobody is asking you to endorse fully financing out of Medicare. That's the point I'm trying to make, okay? Are we clear?

DR. COOMBS: So I understand that, but I was just saying that I support the first three bullets.

MR. HACKBARTH: Okay. We need to pick up the pace here or we're going to be here until my bedtime. So Kate.

DR. BAICKER: So as far as the ASC recommendation, I'm fine with it. I agree with Mike's perception that from the data that have been presented, one might also have come to a zero update conclusion and that there's enough uncertainty that it's hard to differentiate between those and we need better data.

And just to contribute to the SGR conversation, I'd add to your statement of the current state of affairs that, in fact, we didn't vote on the specific line items in that list, that I think we had some diversity of feelings about those line items, and that the message I think we all

agreed to was there's some painful stuff has to happen if you're going to do it from within the Medicare budget and that a combination of potentially painful approaches would be necessary. Which among that menu we would choose, I think we probably had some very different ideas about. Nor are we recommending any particular subset of those menus. But I think it was really helpful to lay out, like, here are the kinds of things you have to do. Here are the price tags associated with them. If you're going to choose, you're not going to be able to pick some easy low-hanging fruit. It's going to be something substantial from this list.

But I want to just be clear that even in the world in which it's all getting financed from Medicare, which we are not suggesting is the outcome we desire, there's still a lot of room for debate within that list and it's clearly not going to be easy but just gets more painful over time and has to get done.

MR. HACKBARTH: And thanks for that, Kate. I agree with all that.

Now, in point of fact, we have gone back on some of the specific items on that list and formulated them as specific recommendations on which we voted after we did more

analysis and the like.

Dave.

DR. NERENZ: Okay. I'm generally fine with the recommendations.

If we could go back to Slide 16, just a couple of brief points about that, and this is SGR again. My first observation is that I understand -- I really appreciate your discussion about this constraint and how this was that if it had to be done this way, here is what we would do.

In reading the October of last year letter and looking at our materials this morning, I think, at least in my mind, a false impression has been created that the constraint is even tighter than you declared, meaning it appears, incorrectly, that this is being done within the physician payment segment of Medicare, only in the sense that -- and there's some people who are nodding -- I know that's not correct, but I'm just saying, as we present this material, simply because we've created a direct link in the discussion between SGR and the particular recommendations about physician payment. I have seen less clear connection between SGR and the other things.

And I just was re-reading again the October 2011

letter. Almost all of the text is about a connection between SGR and specific physician payment recommendations. The rest is in an appendix. Now, it's there. I understand it's there. But I'm just suggesting, if we're refreshing this, we may bring some of those other things more forward just to create what I think is a more accurate impression that our view of SGR is about more than just SGR to physician payment. It's SGR to a set of elements of Medicare payment. Okay. So just support of that.

And then the third major bullet up there, in support of that idea, we have said a couple times that we are intending in some cases to create some uncomfortableness or some incentives to move away from fee-for-service payment. I think we've often been less clear about what we want people to move to. So I think when those opportunities arise, and that would be -- the third bullet here would be an example -- or then Scott hinted at it a while ago, about what if you increased payment to ASCs, when we have the opportunity to say, here is something that we could do that would be an incentive to draw people to something, we should just be as strong and clear as we can about that, as well.

DR. SAMITT: So I support the ASC recommendation

and I have nothing else to say about that at this point.

My remarks are purely about the SGR. I have admittedly had a hard time getting my head around why this is such a hard decision to make. For me, it seems as if there are three options. Either we don't repeal the SGR, is option one, and I think we all recognize that that is disastrous, and living in the world that I live in, this will clearly result in a long-term and short-term access problem.

Option two is to repeal the SGR, but not now, and wait at some point into the future, and what you've highlighted, Glenn, back to your story of 2001, is we only exacerbate the cost -- in fact, it's exponential -- for every year that we don't fix this problem.

And then, obviously, the third scenario is to repeal the SGR and to repeal it now. And so I have a hard time understanding why we wouldn't pick that path.

I would go so far as to say, and I know that it's not our place to recommend how the SGR fix is funded, but for me, there's a golden opportunity right now, which is if Congress does decide to fix the SGR through internal funding from the Medicare program, that creates the exact incentive

that we need to encourage providers to move toward alternative forms of payment. So if the alternative is to live in the fee-for-service world with declining unit-based reimbursement because that's the way the SGR cut will be funded versus pursuing an alternative, which would be bundled payments or value-based payments, what better moment than now to instigate that transformation than to do exactly that.

MR. GEORGE MILLER: Well, first of all, let me say that Craig teed up very nicely the whole notion that we need to look at an alternative method of payment for the entire health care program so we can stop the issue of dealing with silos, because we sometimes pit side against side trying to protect one silo versus others. So let me do -- let me move on to what Peter teed me up.

I am really concerned -- I support and helped restate the SGR recommendations. I have a problem with recommending additional funding for ASC, and let me tell you why. In the material, and I thank the staff for providing the material, there's some very clear differences demographically in the material about the access to care for dual eligibles, for Medicaid populations, and for

minorities. That troubles me very deeply. The numbers are irrefutable. They are very stark and I just have a major problem of recommending additional funding, particularly because we don't have cost data. We picked on and have discussed the HOPDs, but there's cost data, and I understand the rationale.

What I have not heard in this discussion about all of these issues is -- and for me, it's the stand-by capacity, dealing with hospitals -- there is a cost for that stand-by capacity. I don't know if we've ever done an analysis of what it costs to have that stand-by capacity, how much of it is unfunded mandates. And then we compare other settings to provide care and say, well, their HOPD should be paid the same level for care because they don't have that stand-by capacity.

Anecdotally, I can remember three natural disasters that happened and our hospital and other hospitals sent folks to help, and partly we're able to do that because of stand-by capacity.

But getting back to the central point, today, there's no cost data for ASCs. My major problem, again, is the access issue with those three groups I say are not well

represented at all with the ASCs. And again, as Peter indicated, there's no CHF-type ASCs in America or pneumonias or congestive heart failure centers. There is a reason ASCs are there, and maybe they need to be there, but there's a specific reason they are there and my problem is they don't serve the entire Medicare population.

MR. HACKBARTH: George, what would be your preference to do with the ASC update? Zero update or a reduction?

MR. GEORGE MILLER: At the most, a zero update. At the most.

MR. HACKBARTH: Okay.

Just one clarification, I think it’s Ariel or Dan that I’m directing this to.

ASCs now use a patient classification system like is used for hospital outpatient departments, but the conversion factor is different. What is the difference between the conversion factor for ASCs versus HOPDs?

DR. ZABINSKI: The conversion factor itself is 73 percent higher in HOPDs.

MR. HACKBARTH: 73 percent higher? We pay ASCs 73 percent of the rate that we pay --

DR. ZABINSKI: No. The HOPD rate -- flip side.

DR. MARK MILLER: [off microphone.] Express it the way he wants it.

DR. ZABINSKI: 57 percent.

MR. HACKBARTH: Okay. So we pay ASCs 57 percent of the rate paid to HOPDs for the same service. I just wanted to make sure you understood that.

MR. GEORGE MILLER: Yes, I got it.

MR. HACKBARTH: Bill.

DR. HALL: I remain supportive of our SGR recommendations and also the ASC recommendations.

And just very briefly, for the record, the arguments that have been coming forward in the public about the gravity of the SGR situation oftentimes are expressed in terms of what this will do to physician and other health care providers, in terms of being able to cover their expenses to continue to provide services.

And I think there's a tendency to think well, these are people who are not too bad off financially to begin with, what's the big deal here? I think the really grave and serious issue is that once we deprive older Medicare recipients of access to primary care, it's not a

neutral event. Bad things happen. They flood our emergency rooms with chronic illness exacerbations that could have easily been preventable. They take either too many or not enough drugs or the wrong drugs. They keep going and they fall down.

They're a little bit like people on the unemployment list. They come off the list because they stop trying to get health care. Their expectations tend to be much less demanding as, say, 20-year-olds who don't have health insurance.

I think that's the real issue and that's really what we should be about in this Commission, and we are, of course.

DR. NAYLOR: Briefly, this was really another -- I guess, ditto, excellent report all around.

I also appreciated the issues and attention on access reinforced by multiple other surveys which, I think, helped us to understand what the challenges are.

I support the urgency of acting on SGR and maybe only recommend one tweak in the recommendation, that we say that our action is to ask Congress to implement the recommendations of....et cetera.

On ASC, I would support the Chairman's recommendation. Two minor suggestions, in terms of the chapter itself is to really capture the robust workforce that's evolving for primary care as I've described; and also to explore the possibilities of continued development in the quality measures that reflect less a process and doing things and more of what we want as outcomes.

Thank you.

DR. HOADLEY: On the ASC, I can support the recommendation. Like a couple of people, Mike and Kate and George have talked about I could also support a zero update.

I think, as Alice first raised, putting the value-based purchase program language back in, or at least referring in a clear way to it again, is probably useful.

On the SGR stuff, I certainly can support the direction of these policies. And maybe what's interesting in the conversation today is a number of different ideas about ways that in the text or in testimony or wherever, sort of some of the reframing work, reemphasizing the issues. The way you've stated it a couple of times, the big three principles.

Mike talked about despite all of the things that

we've looked at about access and saying that the anecdotes of access problems aren't necessarily supported by the data. You can't assume that that further will continue if we're talking about a substantially different level of payment. And anybody that anybody wants to link sort of our findings of what's happening today as we've been basically stable in payment, that's not a fair extension from what we found on that.

And some other things that I don't need to repeat.

MR. ARMSTRONG: I, too, support the recommendations for the ASC payment changes.

And on the SGR, I want to affirm that I think in my tenure as a Commissioner, that's the best work we've done. I strongly support it. I actually happen to believe that the cost of repealing the SGR should be borne by the Medicare program. I realize that's not a recommendation but that's my personal point of view.

I thought Craig's point was excellent, that it is a great piece of work and it could be even more impactful if it gets implemented and it creates an opportunity to really move changes in our payment policy towards some of the goals that it outlines.

The last point I would make is that our issue with the SGR recommendation is that there were a lot of ideas in there that we had already been discussing in the context of other chapters or other topics. It may be worthwhile in January to just check to make sure that some items on that list are not already counted on, or the status of all that stuff is still consistent with what we assumed it was in October of 2011.

DR. REDBERG: I passed on the clarifying questions because I just wanted to make a few comments related really to the overall theme. Looking at our quality measures because whenever we make changes we want to be sure we're ensuring quality, I just would point out that I think we could use more quality measures looking at overuse. Because right now we're looking at, for example, breast cancer screening. But how about quality measures that you're not getting mammography more often than you're supposed to? That we're not doing mammography in women over 85, that we're not doing pap smears in women who don't have a uterus -- or a cervix, that we're currently doing.

Basically the U.S. Preventive Services Task Force makes some clear recommendations but Medicare pays for a lot

more cancer screening that is not in the interest of our beneficiaries.

And so I would, when we are thinking about reorganizing, think about overuse measures and appropriate use measures. Because the other big pocket we looked at was imaging. I was actually surprised because when you showed us the decrease in imaging, all of my colleagues in cardiology have been saying look at this, our imaging is not going up. But if I understood correctly, it's not that it's not going up, it's just going up in the outpatient setting and it's not going up where it's now reimbursed less.

And certainly, I think a lot of that imaging is not going towards better patient outcomes. There's clearly been a big increase in imaging. Some of our Medicare beneficiaries are now getting as much radiation as Hiroshima survivors. So I think that we really need to look at appropriate use of Medicare services when we're looking at the bigger picture.

With regard to our specific recommendations here, I support the SGR recommendations. I think if we don't repeat it now, we're just going to be sitting here in 10 more years and it's going to be even more expensive. It's

clearly never going to work. I support the recommendations to repeal.

I also support the ASC update and agree with -- I would support the Chairman's recommendation, although I could go lower, as well.

MR. HACKBARTH: So as we've gone through the latter stages of this, I've been thinking about the SGR message and ways to maybe just sharpen it a little bit to reflect this conversation.

Mike suggested the idea of SGR First ought to be our message. Don't continue to use Medicare savings for other purposes while just kicking the can down the road on this. That's another way of creating more focus, more urgency about fixing this now.

Anybody have a problem with SGR first as part of our message here? It seems consistent with the themes that I heard. Bill?

DR. HALL: As long as we nuance it in terms of the benefit to the Medicare recipient, not the health care provider. I think that's a very important -- that's the way we should do it.

MR. HACKBARTH: Yes. SGR first in the name of

assuring adequate access to care for Medicare beneficiaries.

DR. HALL: And ultimately saving health care dollars.

MR. HACKBARTH: Yes.

DR. BAICKER: I think one wants to be a little careful in thinking about first relative to what else. There are all these things that we said are important, and we don't want to verge into the territory where we don't belong of trying to optimize across Medicare and other uses. And SGR first, while I think individually we might think is a great idea, there's a risk in making it sound like we're saying at the expense of other programs or other -- it's a little dangerous.

MR. HACKBARTH: So we'll think some more about how to formulate that but I just wanted a quick test of whether that rang a bell for people.

Okay, thank you all. I appreciate your great work on this.

Next up is skilled nursing facility payment.

[Pause.]

MR. HACKBARTH: Whenever you're ready, Carol.

DR. CARTER: Okay. We're going to be spending the

rest of the meeting focusing on the adequacy of Medicare's payments for post-acute care. This is work we are required to do, and it is important for ensuring beneficiary access to high-quality care.

But before I get started, I wanted to remind you of the second body of work that looks across silos. Much of this work examines broad reforms aimed at matching patients who need post-acute care to the settings that provide the best outcomes at the lowest cost. The Commission pursues both bodies of work, acknowledging that each is critical to the success of the program.

Just first, a definition. When we talk about post-acute care, we are referring the providers listed on this slide.

Our work on payment accuracy focuses on ensuring that payments are adequate to cover the costs of an efficient provider, but not too high that the program incurs unnecessarily high spending. We refer to this as the level of payment. In some sectors we see significant variation in provider costs that are not explained by differences in the patients they treat. In SNFs and home health agencies, we have found a set of relatively efficient providers that

restrain their costs and furnish high-quality care while maintaining high margins. We plan to expand our efficient provider work to other PAC sectors.

Beyond this look at the level of payments, we consider the distribution and whether there are systematic biases within each payment system that result in paying too much for some services and not enough for others. Poorly distributed payments encourage the selection of some patients over others and the provision of certain services, even when they are not necessary. This work often leads to recommended changes to the payment systems.

Another strand of work looks at program integrity issues, such as utilization patterns that raise questions about whether services met coverage rules. In home health care, this work resulted in a recommendation to conduct medical reviews in counties with unusual service use.

We have identified several shortcomings in post-acute care that cut across settings and undermine the efficiency in delivery of care. The first is that post-acute care is not well defined, and the need for these services is not always clear. Some patients can go home without it, and others need it but receive varying amounts.

Another problem is that settings overlap in the services they furnish and the patients they treat, yet Medicare pays very different rates depending on the setting.

For example, patients recovering from strokes are treated with home health care and in IRFs and in SNFs, and a small share are also treated in LTCHs. The quality and patient outcomes cannot be compared across the settings because there is no common patient assessment instrument. And, finally, there are no incentives to encourage care coordination between providers or safe transitions home.

Appreciating the limits of the FEE-for-service world, we have conducted work on at least four broad payment reforms that encourage getting beneficiaries the right services at the right time for the right price. These reforms include bundled payments and accountable care organizations; a common patient assessment instrument; the development of risk-adjusted, outcomes-based quality measures; and the alignment of readmission policies across settings.

Bundled payments and ACOs are reforms that create larger units of service, in the one case for all post-acute care following a hospitalization, and in the other for

assuming responsibility for a population. In both, providers have an incentive to get patients to the right services at the right time, coordinate their care, and use resources efficiently. The Commission recommended testing bundled payments back in 2008, and we have ongoing work on PAC bundles. We also commented on the proposed rules for ACOs and continue to monitor their progress.

The second broad reform work focuses on whether to require PAC providers to use the same patient assessment tool. Back in 2005, the Commission called for such a tool so that all patients, their service use, and outcomes could be compared across settings. CMS completed a mandated demonstration of a common assessment tool in 2005. It found that such a tool was feasible, and its analysis of resource use indicated the potential for a single payment system across institutional settings.

The Commission has also focused some of its work on developing risk-adjusted, outcomes-based measures of post-acute care so that the efficacy of settings can be assessed. Given the goal of much post-acute care is to go home, we have developed risk-adjusted rates of discharge to the community for SNFs and IRFs. Rehospitalization,

especially for those that are potentially avoidable, are a good gauge of the care furnished by the facility, and we now use this measure in evaluating the quality of SNFs, IRFs, and home health agencies. Extending rehospitalization measures to include a period after discharge holds providers accountable for safe care transitions, and we have also developed such measures for these settings.

Finally, the Commission has examined expanding readmission policies across settings so that hospitals and post-acute care providers have -- that the incentives are aligned and focus on unnecessary rehospitalizations. Such policies would hold PAC providers along with hospitals jointly responsible for the care they furnish within their own setting and for safe transitions between them.

And with this overview of the cross-sector work, I'll begin our silo-specific analysis of the adequacy of payments for the PAC settings, and I'm going to start with SNFs.

First, I wanted to thank Lauren Metayer for her work and help on this chapter. I'm going to start with an overview of the industry and then present some information related to the update and end with a summary of the Medicaid

trends that we are required to report.

Here's a quick overview of the industry. There are just over 15,000 providers -- I mean just under 15,000 providers, and about 1.7 million or just about 5 percent of beneficiaries use SNF services. Program spending in 2011 was almost $32 billion, and Medicare makes up about 12 percent of days but 23 percent of revenues.

We'll be using our adequacy framework that at this point you're quite familiar with. This work this year, the Medicare cost reports for free-standing SNFs were not yet available, and so in some places I've indicated what the analysis found last year, and I'll describe our estimates of 2011 margins.

Access is stable and adequate for beneficiaries. Supply has been steady, with a slight increase in providers billing Medicare between 2010 and 2011. Three-quarters of beneficiaries live in counties with at least five SNFs, and the majority live in counties with ten or more. Covered admissions and days were essentially unchanged between 2010 and 2011. Last year, I reported that there had been no change in bed days available or occupancy rates, but this year we didn't have updated information on that.

Turning to quality measures, we look at two measures: risk-adjusted rates of discharge back to the community and risk-adjusted rates of rehospitalization for patients with five potentially avoidable conditions. Those include CHF, respiratory infections, UTIs, sepsis, and electrolyte imbalance. We see that there has been little improvement in these rates since 2000.

Last year, the Commission recommended a rehospitalization policy to hold SNFs accountable for potentially avoidable readmissions. This policy would align hospital and SNF incentives and hold both settings responsible for unnecessary readmissions. You noted that the measure should include a time period after discharge from the SNF like the hospital measure does, and we worked with the contractor to develop a risk-adjusted measure of rehospitalizations for patients during 30 days after discharge from the SNF.

In 2011, the combined rehospitalization for beneficiaries while they are in the SNF or in the 30-day period after discharge was 28 percent, with large variation in both the within SNF and after discharge portions. Both the level and the variation suggests considerable room for

improvement and potential savings for the program.

In terms of access to capital, there was more lending in 2012 than there was in 2011, and HUD, the largest lender to the sector, is expected to maintain its lending at the same level next year. Non-HUD lending is also expected to keep pace with 2012 levels, though there is some uncertainty about federal and state policies. Medicare continues to be the preferred payer in this sector, and lenders and the industry use Medicare shares to gauge the financial health of facilities.

As I mentioned before, the cost reports for free-standing SNFs were not available for calculating margins for 2011. Therefore, we estimated margins using 2010 costs trended forward, and we used 2011 claims to estimate payments. We estimate the 2011 Medicare margin to be between 22 and 24 percent, and this reflects the overpayments that occurred within the new case-mix groups were implemented. Even after the rates were lowered to put them back in line with where they had been, margins for 2013 are estimated to be between 11 and 14 percent.

We didn't estimate margins by SNF group such as by location, urban-rural, or by ownership group, but it's very

likely that the patterns that we've seen for many years continue to hold true. There is a wide variation in margins, and there's a large group of relatively efficient providers with considerably lower costs per day, better quality measures, and with high margins.

Last year, the Commission made a two-part update recommendation. For the update year, you recommended that the PPS be revised with no update, and then in the second year, payments should be lowered by an initial 4 percent with subsequent reductions made during a transition until payments were more closely aligned with provider costs. For those of you who were not here last year, I want to explain the logic of this recommendation.

With SNF margins being so high for so long, the Commission believed that Medicare payments needed to be lowered. However, we knew that margins varied widely and reflected systematic shortcomings in the PPS. Most importantly, payments are driven by the amount of therapy furnished, and payments are not targeted to patients with high non-therapy ancillary costs, such as drugs.

In addition, the PPS does not have an outlier policy. The Commission believed that before rebasing began,

the PPS needed to be revised to correct these biases. The Commission first recommended revising the PPS back in 2008. Without raising total spending, an alternative design would shift payment within the industry. Payments would decrease 10 percent for SNFs that furnish a lot of intensive therapy and would increase 17 to 18 percent for clinically complex patients.

Based on a facility's mix of cases and their therapy practices, payments would shift from free-standing SNFs to hospital-based providers and from for-profit to nonprofit SNFs, that is, from the highest-margin providers to lower-margin providers.

The second part of the recommendation stated that payments would be rebased beginning with the 4-percent reduction. The Commission reviewed many pieces of evidence that supported this reduction. First, aggregate Medicare margins for SNFs have been above 10 percent since 2000. Variation in Medicare margins is related to the amount of therapy furnished, not differences in patient mix.

Differences in facility costs -- I think I went a little -- sorry. Differences in facility costs are unrelated to wage levels, their case mix, or beneficiary

characteristics. We've also found -- we've looked at relatively efficient SNFs, and compared to other facilities, we find that efficient have costs that are 10 percent lower, community discharge rates that are 38 percent higher, and rehospitalization rates that were 17 percent lower. And yet they still had above average Medicare margins.

Another piece of evidence is that MA payments are considerably lower than fee-for-service payments. When we looked at five publicly traded chains, fee-for-service payments averaged about 27 percent higher than MA payments. It is unlikely that these large differences in payments are explained by their mix of enrollees.

And, last, the industry has responded to the level of payments in two ways. First, cost growth has outpaced the market basket every year since 2001. And, second, revenues grew even when steps were taken to lower their payments.

The payment adequacy factors indicate that the SNF landscape has not changed very much during the past year. The Chairman proposes to maintain last year's recommendation with a discussion of why these changes are still needed.

The language of last year's recommendation is on

this slide, and it would decrease spending relative to the statutory updates, and we do not think it would affect beneficiary access to care or provider willingness or ability to care for beneficiaries.

As required by PPACA, we examined Medicaid trends and spending, utilization, and financial performance for nursing homes. About 15,000 facilities participated in Medicaid, and that was a small decrease from 2011. Between 2008 and 2009, which is the most recent year of data, the number of users increased slightly to 1.6 million. Spending was just over $50 billion in 2012, and that was a slight decrease from 2011. Because we did not have cost reports, we estimated non-Medicare and total margins for 2011. In 2011, the aggregate non-Medicare margin is estimated to be between negative 1.2 and negative 3.2 percent, while the total margin, which includes all sources of revenue across all payers, was estimated to be between 3.8 and 5.5 percent. And these are improvements over 2010.

The industry consistently posits that facilities lose money on Medicaid and need the high payments from Medicare to be viable. Using Medicare payments to subsidize Medicaid payments is poor policy for a number of reasons.

Using Medicare days to direct subsidies to Medicaid ends up helping exactly the facilities that need help the least. It also doesn't discriminate between states with relatively high and low payments, which we know vary two-fold. Even after adjusting for wages, there's that much variation.

Medicare's high payments subsidize facilities even in states with relatively high Medicaid rates. If Medicare raises or maintains its high rates, it could encourage states to freeze or lower their rates. And, finally, payroll taxes redirect trust fund dollars to subsidize payments from Medicaid and private payers. If the Congress wishes to help nursing facilities with a high Medicaid mix, then a separately financed and targeted program should be established to do this.

And with that, I look forward to your discussion. I'll just put up the Chairman's proposal right here.

MR. HACKBARTH: Okay. Thank you, Carol.

Herb, have you gone first?

MR. KUHN: No. And I would be happy to do so. Thanks, Carol. Three quick questions.

One, on page 3, when you talked about 12 percent of the days are about, what, 24 percent of the revenues, or

thereabout, if I recall right, maybe five years ago it was like 10 percent, 20 percent. So has that gradually grown over the last decade in terms of the number of days as well as the percent of Medicare revenue?

DR. CARTER: I don't have that right in front of me, and I think that's an easy fact to get.

MR. KUHN: And the second question, on the rehospitalization issues, does the claims data permit us to kind of understand the time of day when we're seeing those rehospitalizations? That is, are they coming during the day between 8:00 and 5:00? Or are they predominantly the evenings or on the weekends? Do we have a sense of that at all?

DR. CARTER: We don't have data on that.

MR. KUHN: Okay. And then, finally, I'm curious about --

DR. CARTER: Well, I will say one interesting thing anecdotally that I hear is that you do see more admissions on Friday -- readmissions back to the hospital, where staffing might start to get nervous and they know kind of what the staffing levels might be on the weekend, and so there is -- and that part, that is day of readmission where

you could probably --

MR. KUHN: Right, I have heard that as well and was just curious if the claims data permitted to understand, you know, to quantify that.

The final thing I was curious a little bit about is the intensity of therapy services, and now with the inpatient rehab facilities and the lockdown of the 60-percent rule, so we're starting to see more therapy services move to home health or to skilled nursing facilities, how much of the increase in volume that SNFs are seeing are a result of the movement from the IRFs to the SNFs? Do we know?

DR. CARTER: There's a little pickup for SNFs, but actually the bigger beneficiary, if you will, of that was -- I think more of those patients actually went to home health. And that I think has pretty much stabilized by now.

MR. KUHN: Okay. Thank you.

MS. UCCELLO: So another observation status question. I remember policymakers and articles and stuff bringing up this three-day rule on observation status, but nothing has changed. Is that correct? The observation status still would not count toward the SNF eligibility?

DR. CARTER: That's right.

MS. UCCELLO: Thank you.

DR. DEAN: In terms of the payers, did you -- maybe I missed it. What is the proportion of Medicaid payers?

DR. CARTER: About 60 percent.

DR. DEAN: 60 percent, okay. Thank you.

DR. COOMBS: Carol, I think you've actually given this information before. What percentage are from home for the SNFs?

DR. CARTER: Well, to qualify for the SNF benefit, you have to have been hospitalized previously.

DR. COOMBS: So you have to come via the hospital.

DR. CARTER: Yes. You don't have to come immediately, but I think most do.

DR. COOMBS: So if you go home for, like, a certain amount of time, then you can bounce into the SNF?

DR. CARTER: Yes. And I --

DR. DEAN: 30 days.

DR. COOMBS: Is it 30?

DR. DEAN: 30 days.

DR. CARTER: It's 30 days, right. And I don't

think I actually looked at who went home first and then quickly went to -- I haven't looked at that.

DR. COOMBS: Because indirectly that might be an artifact -- it may be artificial, if they were in a hospital, went home just for an intermediary period, and then bounced into a SNF in terms of readmissions, you know, if they were -- I don't know how you could capture that information.

DR. CARTER: Well, when we're looking at readmissions, we're, like, okay, so now you're in the SNF, and are you going back to the hospital? So that's when the readmission starts to count. So if somebody goes home and then gets admitted to a SNF, we would only count that if the person then went back to the hospital.

DR. COOMBS: Back to the hospital [off microphone].

DR. COOMBS: Yeah.

DR. REDBERG: In looking at the SNFs, you gave us some of the costs and the quality measures, and it looked like there hadn't been a lot of change. Were there any predictors of the ones that might have been at the upper end of the quality, like rural versus urban or geographic

variations or anything else?

DR. CARTER: There is some geographic variation. There's also variation by ownership, and there's a little bit of variation by whether your hospital-based versus free-standing. And I think -- we have a lot of information about sort of the distribution and what those look like, and I can get that to you.

DR. REDBERG: Thank you.

DR. HOADLEY: You mentioned or raised in the meeting materials the new settlement on the improvement standard and the fact that that may lead to some increased utilization. Is there any sense in your mind of whether the changes that you're recommending or the Commission has recommended on the payment system would help in any way, or is it just neutral to whatever might have gone on? Or is that something you've even thought about?

DR. CARTER: To the extent that payments would better reflect a patient's need for resources, then payments in theory would be better matched, and they might get lower in the sense that patients might not get therapy that they currently get, even though they may not need that. And particularly with the relaxation, if you will, of requiring

improvement, you might think patients would get less therapy. So in that sense, I think there might be even more interest to revise the PPS so that they're better matched to the patients that are in -- the care needs of the patients that are there.

DR. HOADLEY: I mean, obviously there's nothing you can do empirically to talk about that, but maybe it's worth sort of thinking through that argument, making a little bit of that case as a further strengthening of...

DR. NAYLOR: The risk adjustment method for the 30-day readmission, I know you had comorbidities and function. Was cognition a part of -- cognitive status a part of the methodology?

DR. CARTER: You may know this, but the MDS, the new MDS data has much better clinical information

DR. NAYLOR: Yeah.

DR. CARTER: So the comorbidity index that we use has many elements of mental status and cognitive -- it doesn't have like the CPS score, but it has things like five or six different measures of mental illness in it now that it didn't used to.

DR. NAYLOR: Okay.

MR. BUTLER: Two questions. I am ready, believe it or not.

[Laughter.]

MR. HACKBARTH: Could have fooled us.

[Laughter.]

MR. BUTLER: Such an encouraging group. I'm going to pause.

Okay. We worry a little bit about the hospice care that also goes on in the skilled nursing and the potential -- from an ownership standpoint, do you know of any situations where you have common ownership over the hospice and SNFs so that --

DR. CARTER: I would say yes, and I'm going to turn to -- I think it's yes and a growing business element of firms that own nursing homes and SNFs, I think hospice is a growing arm of their business. Is that a fair statement? Yeah.

MR. BUTLER: Okay. So the other question is, you know, we're repeating the previous year's recommendations, but I don't see us articulating the impact budgetarily, maybe because we did last year, so it's not restated here. But this was actually one of those things in the SGR letter

that had a big -- a $23 billion number associated with it, so I assume that, you know, as we look at this compared to -- going back to the early-morning discussion on sequestration and what -- there's no statement here that reflects the savings that we can now, as Mike suggests, direct toward SGR. What would the number be?

DR. MARK MILLER: I wouldn't want to say a number offhand, but the process is coming in January and have our usual buckets, and as part of that process in January, I should be able to answer your questions.

MR. BUTLER: Okay.

MR. HACKBARTH: Although we're rewriting a previous recommendation, we will still have a bucket --

MR. BUTLER: Well, some of the other materials today have stated the impact. This one didn't, and I just -- okay.

DR. MARK MILLER: It's probably more of an oversight than anything else [off microphone].

MR. HACKBARTH: Mike, clarifying questions?

DR. CHERNEW: [Shaking head negatively.]

MR. HACKBARTH: Let me just ask one, Carol.

Would you put up slide 6? Well, it’s six in the

SNF package. It's the quality measures graph. There we go.

As you know very well, I know nothing about the quality measurement. But when I look at measures that there's this little activity for this long a period of time, as a layman I wonder whether it's a very sensitive or useful measure.

So I guess a question about it is if this is the average across all SNFs, if you look at individual SNFs do you see movement, differences in level, differences in trend, and it just happens that that all averages out to a long, flat line? Or what?

DR. CARTER: As I mentioned to Rita, there is a lot of variation. There's about a 60 percent variation in these measures within the sector each year. But I don't have in front of me to accurately state what you're looking for, which is sort of within -- over time, what's going on? Do you see a lot of bouncing around? And I don't know that.

MR. HACKBARTH: I can't think of any other measures that we've looked at that have this pattern, this utter lack of movement over a long period of time. And that's what prompts the question.

Herb, round two?

MR. KUHN: I think rerunning the recommendation from last year makes sense and I support doing that.

MS. UCCELLO: Me, too.

DR. NERENZ: [off microphone] I support [inaudible].

DR. COOMBS: I support the recommendation.

DR. REDBERG: I support the recommendation.

MR. ARMSTRONG: Me, too.

DR. HOADLEY: Likewise.

DR. NAYLOR: Just stay there, yes.

DR. HALL: I'm good.

MR. GEORGE MILLER: I'm good.

DR. SAMITT: It's good to me, too.

DR. NAYLOR: I support the recommendation.

DR. BAICKER: Ditto.

MR. BUTLER: I'm not ready.

[Laughter.]

MR. BUTLER: I support the recommendation.

[Simultaneous discussion off microphone.]

MR. HACKBARTH: Thank you very much.

Next up is home health.

Actually -- oh, never mind. I'll do it next time.

Evan, go ahead and proceed with home health.

MR. CHRISTMAN: Good afternoon. Now we'll go through the framework as it relates to home health.

As a reminder, here is our framework. It is the same one for the other sectors you had in earlier presentations.

Before I begin, I want to remind you how the home health benefit works. To qualify for the service, beneficiaries need to be homebound and have a need for therapy or nursing. Home health plays an important role in serving beneficiaries who have trouble leaving home to receive care. A common use of the service is for beneficiaries returning to home after hospitalization, though a prior hospitalization is not required in order to receive the benefit.

Medicare pays for home health under a PPS. The PPS makes case-mix-adjusted payments for each 60 days of service.

The Commission has noted several challenges with the home health benefit. First, the benefit is broadly defined and permits beneficiaries to remain on service for long periods of time.

The benefit has an unfortunate history of fraud and abuse, and the paper notes many areas with aberrant patterns of utilization. In addition, providers in this sector also have a history of tailoring services to reflect the financial incentives under Medicare payment, and I'll say more about that in a few slides.

Medicare spent about $18 billion on home health services in 2011. The program provided about 6.9 million episodes to 3.4 million beneficiaries.

We begin with supply. As in previous years, the supply of providers and the access to home health continues to increase. Ninety-nine percent of beneficiaries live in an area served by one home health agency; 80 percent live in an area served by five or more. While there are some areas that lack home health agencies, they are relatively few in number.

Turning from access to supply, the number of agencies was over 12,000 by the end of 2011. This was a net increase of 512 agencies in 2011, with 730 agencies entering the program and 218 leaving.

Next we will look at volume. The volume trends in 2011 are a departure from what we have reported in prior

years. For the first time we see little significant growth in the number of users or episodes, as shown in the right-most column in this chart. However, this break in growth comes after several years of rapid increases. For example, the number of users increased by over a third in 2002 through 2010 and the number of episodes increased by 69 percent.

We are still reviewing the factors that could account for this slowdown in growth in 2011, but it is notable in this year that CMS put into place a new requirement for physicians to conduct a face-to-face examination of beneficiaries for whom they order home health. It is possible that the additional scrutiny required by this examination led to fewer referrals.

Home health spending declined by 5 percent in 2011. This decline was mostly due to a 5-percent reduction in the base rate CMS implemented in this year. Similar to the changes in volume, this decline comes after many years of growth. Aggregate spending on home health roughly doubled between 2002 and 2010.

The home health PPS currently uses per visit payment thresholds that increase episode payments when

additional therapy visits are provided. The Commission observed two problems with this arrangement.

First, the use of the number of visits as a payment factor permitted agencies to target their care protocols to the number of visits that were most profitable. In years when CMS has set or revised the therapy payment thresholds to redistribute payments, agencies have increased the volume of episodes with higher payments after the revisions and decreased volume for the therapy episodes with lower payments after the revisions. These timely shifts in volume suggested that financial incentives may be overriding patient needs when therapy plans of care were set.

Second, therapy episodes increased faster than other services in home health. We found that agencies which provided more therapy episodes had higher margins. These findings suggested that therapy was overvalued relative to other services in the PPS.

Based on these findings, we recommended that CMS eliminate therapy thresholds and set payment for these services based on patient needs. This budget-neutral change would have been redistributive and would increase payments for low-margin providers and reduce them for higher-margin

providers.

CMS recognized the vulnerabilities of the system that we cited and made two changes, but it has left the system of payment thresholds in place.

CMS has tightened the review requirements for episodes with 14 or more visits, and the intent of this review was to ensure that patient needs were being considered before additional visits were provided. This requirement appears to have had some effect as the volume of episodes subject to this requirement declined in 2011.

However, these additional review requirements did not apply to 70 percent of therapy episodes. The volume of these episodes continued to increase. It is striking that episodes not subject to the new review requirement continued to grow while those that were declined and suggests that further safeguards might be beneficial.

Perhaps most importantly the need for an additional review requirement could be eliminated if CMS implemented our recommendation to end the use of the thresholds and use patient characteristics to set payment for therapy services.

A second change in 2012 recognized MedPAC's

concern that therapy was overpaid relative to other services. CMS raised payments for non-therapy services and reduced them for therapy services through adjustments to the case-mix index. This would address at least some of our concern that therapy services are overvalued relative to non-therapy services.

However, even with these two changes, the visit-based payment thresholds remain in place, and payment for an episode increase as additional therapy visits are provided.

Our next indicator is quality. This table shows the risk-adjusted rates of functional improvement among those patients not hospitalized at the end of their home health episodes. Across the two years, you can see that the rates of functional improvement increased slightly on most measures, implying a modest improvement in quality.

A limitation of these measures is that they do not measure quality for beneficiaries that were hospitalized. These cases may have outcomes that are different from these shown on the table.

Next we look at capital. It is worth noting that home health agencies, even publicly traded ones, are less capital intensive than other health care providers; also,

few are part of publicly traded companies.

Financial analysts have concluded that the publicly traded agencies have adequate access to capital, though because of the payment reductions in the PPACA and several federal investigations into industry billing practices, the terms are not as favorable as prior years.

For agencies not part of publicly traded companies, the continuing entry of new providers indicates that smaller entities are able to get the capital they need to expand. As I mentioned earlier, over 700 new agencies entered Medicare in 2011.

Next, we turn our attention to margins for 2011.

You can see that the overall margin for free-standing providers is 14.8 percent. However, there is some variation in the margins. The agency at the 25th percentile had a margin of negative 0.3 percent, while the agency at the 75th percentile had a margin of 23 percent. Margins for providers that primarily serve urban patients were 14.8 percent and 15.3 percent for agencies that primarily serve rural patients.

We also examined the distribution of margins for rural providers, and they exhibited the same distributional

pattern as urban providers. From these facts we can conclude that the aggregate level and distribution of margins is similar for urban and rural providers.

For-profit margins equal 15.7 percent; nonprofits' were 12.2. These margin estimates are our starting point for estimating 2013 margins. These numbers highlight two concerns that the Commission has had for many years: that home health margins have been excessive and the wide variation in margins.

This year we are also examining the performance of relatively efficient home health agencies compared to other agencies.

We identified relatively efficient home health agencies by examining cost and quality for a three-year period. Agencies were classified as relatively efficient if they were consistently in the top third of at least one of these measures in each of the three years and not in the bottom third on the other measure. About 14 percent of the agencies in our sample met this criteria.

Relatively efficient providers had a cost per visit that was 15 percent lower then other agencies and Medicare margins that were 28 percent higher. Relatively

efficient providers were typically larger in size, providing about 30 percent more episodes in a year. They had lower hospitalization rates, and they provided about the same mix of nursing, therapy, and aide services to their patients, and they served similar numbers of dual-eligible patients, and their beneficiaries were about the same average age.

These results suggests that relatively efficient providers achieve better performance through lower costs and are typically able to provide better quality than other providers. Some of these lower costs may be attributable to the typical larger size of relatively efficient home health agencies.

Here is the margin for 2013. We estimate margins of 11.8 percent in 2013. This is a result of several payment and cost changes.

PPACA reduced the market basket by 1 percent in 2012 and 2013. In addition, CMS reduced payments in 2012 and 2013 for changes in coding. Also, there is a 3-percent add-on in effect for rural areas in 2010 through 2015. We assumed cost growth of half a percent annually in 2012 and 2013, consistent with historical rates of growth.

Here is a summary of our indicators.

Beneficiaries have good access to care in most areas. The number of agencies continues to increase, reaching over 12,000 agencies in 2011. The number of episodes and rate of use are steady after several years of rapid increases. Quality shows improvement on most measures, access to capital is adequate, and margins are projected to equal 11.8 percent in 2013.

I would note that these are average margins, and our review of the quality and financial performance for relatively efficient providers suggests that better-performing agencies can achieve even better outcomes -- excuse me, even better profits while holding quality constant or doing better than the average provider. I would note that these results overall are similar to what we have reported in prior years.

Since our indicators our largely unchanged from previous years, the Chairman has proposed that next year's report reprint the recommendation approved for the March 2011 report. The Commissioners may recall that current law includes a softer form of rebasing. Our recommendation differs from current law in that it phases in the lower rates faster, in two years instead of four; in addition, our

recommendation eliminates the annual payment update during rebasing. Current law includes the annual update as an offset to the rebasing reductions. Our recommendation would decrease spending in 2014, and we would expect beneficiary access to remain adequate though their may be some contraction in supply.

This completes my presentation.

MR. HACKBARTH: Okay. Thank you, Evan.

Could I ask a question about Slide 7? You noted that after a number of years of rapid growth, that pattern seems to have changed, at least temporarily. You speculated that perhaps one of the reasons might be the physician certification requirement.

As I recall, our work on geographic variation showed that home health and DME and a few other services were huge contributors to geographic variation in total cost per beneficiary. So these dollars are not evenly spread across the map. Some areas have dramatically higher levels of home health spending than other areas. At least some of those very high areas have also been subject to intense scrutiny recently for fraud and abuse, et cetera. Do you think potentially that is also having an effect? Is there

any way to look at the data to see whether the biggest change in the trend is in some of those high-cost areas?

MR. CHRISTMAN: You know, every year we look at the top 25 counties in terms of utilization, and there has been a drop in those areas. They're still very high, and so it may be that some of that is due to a decline in utilization in the high-use areas.

The point I guess I would make is that, you know, laying aside the fraud and abuse, on an annual basis we were having years where we were seeing 200,000, 300,000 new episodes a year. So to go from that to this year where it was approximately 10,000 new episodes, certainly fraud and abuse may be a part of that. But the magnitude of the drop suggested that there might be some broader factors, too.

MR. HACKBARTH: Okay. And then one other question, this one about Slide 10, the quality measures. Remind me, you know, looking just at these, it seems like there might be a substantial element of subjective grading in these measures, that home health agencies are in a sense evaluating their own performance and saying, you know, my patients are doing better at bathing or walking. And if there are incentives for lenient grading, you could get

results that really aren't particularly meaningful.

Remind me, are there instruments, is there some discipline to this grading system that at least alleviates that concern a little bit?

MR. CHRISTMAN: Well, I think I would just note that the -- I would note two things. I mean, this uses the OASIS instrument, so there's a standardized scale that they're being assessed at at admission and discharge. So part of the answer to your question is that there's a set of rules they're supposed to follow when they grade them, but, still, it's the agency, yes, evaluating their own work.

The other thing I would note, I'm not sure this helps answer your question, but the trend in these measures has been relatively stable. They've all increased by one to two percentage points a year, and, you know, I'm not sure that you can see both sides of that, but we do at least see some consistency on what agencies are reporting. But I don't know that there's any secondary data that we could go to to sort of look behind the functional measures.

DR. NAYLOR: Thanks, Evan. I wanted to ask a question about disentangling post-acute, which is immediately following hospitalization, from the rapidly

growing segment of home health, which is the chronic care, not preceded by hospital. And I'm wondering, as you look at the efficient hospital or efficient home health slide, if you can help us to understand. Can you disentangle those two groups?

MR. CHRISTMAN: We can. I haven't done that particular slice of this piece of the efficient provider looking at how many people are preceded by -- what share of their episodes are preceded by a hospital stay, but we can look at that.

DR. NAYLOR: And one in particular, you noted in the report that the efficient home health has a decreased number of visits, 0.8 per episode, and I think it will be really important to know what is the visit pattern per episode when it's post-acute versus chronic, because they're entirely different services.

MR. CHRISTMAN: Right, and I guess I would just -- you know, I'm not sure this is -- my intuition would be that the mix won't vary, I mean, because the mix of nursing, aide, and therapy did not vary between the relatively efficient and all other agencies. And that would lead me to guess that the mix of the prior hospital episodes won't be

that different either. But we can look at that.

DR. NAYLOR: So then can you speculate on why you're seeing one segment grow rather dramatically and another part of home health decrease?

MR. CHRISTMAN: I think that there's two pieces we have to look at to really get that answer right, and there's two things that could be driving it. One is, you know, how many people are getting admitted to home health directly with no prior hospitalization and staying on for however long they stay on. That will be one thing that drives growth in the non-post-acute 60-day episodes.

The second thing that can drive it is, you know, we always give those numbers in terms of how many payment episodes are preceded by a hospitalization, and so what can happen is a patient can be admitted after a hospitalization and then they can stay on for a number of episodes. So their first episode will be look like a PAC episode, but if they have two or three episodes after that, then those will look like non-PAC episodes because they were not preceded by a hospitalization. That's sort of like what's your original source of the admission. And, you know, as PAC patients, people who are originally admitted from the hospital stay

longer, they'll have non-PAC episodes. So sort of tangling -- those are sort of the two pieces to kind of understand what's driving the increase in the non-PAC episodes.

MR. HACKBARTH: Let me ask this. You've made this point a couple times today, Mary, the difference between the post-acute patient and the patient admitted from the community, say somebody with a chronic illness, and it makes great sense to me. Yet in this payment system we're lumping them together. I almost wonder whether we ought to be thinking, if not about different payment systems, but, you know, different conversion factors or some difference in the payment mechanism to reflect, you know, fundamental differences in the two categories.

DR. NAYLOR: I will save this until later or answer it now, but I think this is really fundamentally important. I mean, we're talking about trying to build a care system; the bundled payment is thinking about hospital admission, some of the models, to post-acute. The whole notion of improving transitions of people during a very high risk time is figuring out how to better connect these two. And yet when we look at the data that Evan and others have provided, it shows really -- was it a 117-percent increase

in the use of home health as a community chronic care service rather than in connecting these two?

So I do think it's important for us to know how these services are being used, by whom, for what outcomes you're seeing post-acute in the real traditional sense of hospital to home versus those that are being picked up in the community.

MR. HACKBARTH: Okay. Interesting point.

DR. HALL: It came up several times that with bundling and probably with accountable care organizations that hospitals are going to take a much closer look at home health agencies because they're incentivized to keep people out of the hospital. My experience has been with home health that up to now they have tried to protect themselves against patients that had very high care needs so that they had the right to say this patient is ineligible for home health care services because they have too many problems.

Is there any speculation that this might really change the whole dynamics?

MR. CHRISTMAN: Well, I would say that there's definitely a lot of discussion about home health can partner with hospitals in reducing readmissions. I think in terms

of, you know, will it change -- are there patients that they're not taking now that, you know, they'll decide to take, I really haven't heard too much discussion about that. You know, we hear a variety of different concerns. I think the greater concern we hear, frankly, is in areas that are saturated there's a lot of competition for who's going to get certain patients and concerns that that sometimes results in, you know, business arrangements that aren't appropriate. But, you know, I think there's no requirement that a post-acute provider ever take a patient. I think that, you know, that's a general concern sometimes that I hear about, you know, PAC in general, whether they're trying to place people in SNFs or home health, and if you experience is it occurs in home health, then certainly it's possible.

MR. GEORGE MILLER: Excellent report. I want to focus in on some of the material in the paper concerning the areas where we have more of a challenge with mischief or aberrant behavior.

Has the staff looked at those five states with the usual suspects that we have very high potential overutilization and see what would be the impact if we were

able to eliminate those from the lexicon, from the members, and would the rest of the -- I've heard numbers like maybe half of the aberrant behavior could be in just those five states, and if we eliminate that, what would the rest of the country look like?

MR. CHRISTMAN: You know, we haven't -- I don't think we've quite looked at it that way. I mean, I think we definitely do see that there are, you know, certain areas and really within the states it's usually a few counties, with some exception, you know, that we see high utilization. I mean, I guess it's sort of a question of what you say when you say we eliminate the aberrant utilization. I think that's always -- it's easy for us to identify an outlier. It's a little bit harder to say, you know, how much lower should utilization be in Miami or Hidalgo. You know, we could talk about what it would be if it were the national average, but, you know, there's a significant chunk that would probably get pulled out if you were able to pull things down.

MR. GEORGE MILLER: I'll follow up. That's the question I'm asking. Let's say if those five states were at the median across the United States, what would that do for

spending? And would the focus be -- you know, we've got a lot of extra spending particularly in those five states, and I've heard numbers it's about half of -- and you've got a lot of growth in those five states. So if we did something like put a moratorium or froze payments, would the rest of the country be normal, what we would think?

DR. MARK MILLER: This is the way I would try to answer this. There's a very easy and a very hard part of your question. If you said to us, okay, let's assume utilization rates in, you know, all areas of the country at least were brought down to, let's just say, the 75th percentile, you know, we can do a calculation and tell you what impact that would have on spending if that was a true expression of what happened and what the rest of the country would look like.

I think it's the second part of your question, so if I had a moratorium or so if I did pump a bunch of money into program integrity or so -- you know, however you finish that sentence, would that get me there, that's what I think Evan is more concerned about answering. We can do the calculation. It's useful to say perhaps to the country this represents something of an opportunity. It's always that

next question of, like, okay, so how do I get it? Because some of this, even by its very nature, is avoiding being caught. So the truly fraudulent behavior -- sorry. I put that eloquently as usual.

[Laughter.]

DR. MARK MILLER: And some of it is designed not to be detected, and then some of it is more inappropriate utilization. And I think Evan's point is he can't -- and I think it might even be hard for this group to say this is inappropriate utilization, this isn't, and that's kind of the problem with the whole area.

MR. GEORGE MILLER: But you do have it identified in five states.

DR. MARK MILLER: But the exercise, you know, that you say, the first part of your question, that's not hard to do, and we can certainly put it in and say, you know, pay attention, folks, there's an opportunity here. It's just harder to say how do you put your arms around it.

MR. GEORGE MILLER: Okay.

DR. SAMITT: So I guess my question is in the same vein. Nice job, Evan. I guess I -- this is the slide I'm interested in, you know, is there promise kind of in the

world of bundled payments and accountability that we'll be able to address this. So is there any evidence when you look at the most efficient agencies that they are the organizations that are pursuing ACOs, that they are Medicare Advantage plans, that it's not just payer accountability in search for fraud but it's provider accountability that is really focusing on opportunities for efficiency. I don't know if you've broken it down that way.

MR. CHRISTMAN: I haven't quite looked at it that way. I mean, I think that -- I definitely am sort of watching this space to see what agencies do. Part of the challenge with home health -- I guess it's true of all providers, but they vary substantially in their abilities. The Visiting Nurse Service of New York can probably do any care model you could possibly build. They're the largest home health agency in the country. They operate an MA plan. They have all kinds of different programs that would, I think, be similar to many of the goals that the Commission has for reform.

Then there's a lot of other much smaller agencies that function like a more traditional home health agency, and some of them may be interested in new models of care and

others may be focused on their current model. So I would expect there would be sort of a big range in their preparedness to kind of take the next steps you're talking about.

MR. HACKBARTH: I was struck, Craig, by your comment at the last meeting when we talked about having a pay-for-performance component on home health on readmissions. As I recall, what you said -- and correct me if I missed your point -- was that maybe the best way to get to that destination is not adding a payment adjustment, but hospitals, for example, faced with their own incentive to reduce readmissions will start to be selective in where they refer patients for home health care, and the agencies that are really good at helping avoid readmissions will get more business and that will be a powerful incentive for them to focus on that.

And I think that's potentially a very powerful point, and I wonder whether, when we try to look at what's an efficient home health agency, whether it would be interesting just to look at some case studies of different markets, markets that are more developed in that sense, and see if the home health agencies in those markets perform

differently, have different characteristics, from those where you don't have a lot of ACO activity or really robust Medicare Advantage plans. It wouldn't be an analytic study where you'd say, here's the statistical relationship, but it might be an interesting way of looking at the Samitt hypothesis.

DR. SAMITT: Well, I mean, I think the reality is, is living in the ACO space today, many vendors in our community and many potential partners are coming to us because they're afraid about our selecting different partners, whether it's SNF or home nursing or what have you, and we would like to align with those that are more focused on better care at a lower cost. So you can only imagine that the incentive sitting on the provider side through the form of ACO or other potential penalties or benefits would very much drive the transformation further downstream. So I would welcome sort of an evaluation of that hypothesis because I would imagine it could be true.

MR. KUHN: Glenn, if I could just -- I, too, would find that interesting, but, I guess, isn't -- maybe Evan or Mark or others can answer this -- it's not permissible under current law to do that kind of steering of patients for home

health or SNF, is that correct, if they're in the fee-for-service program?

MR. CHRISTMAN: Yeah. There is a provision -- it's loosely referred to as the Freedom of Choice Provision -- that beneficiaries are supposed to be notified that the following agencies are in their area. But I think that Bill's comments indicate how complicated this can be in the sense that there could be ten agencies in an area, but you'll get to the peculiarities of what agencies will differ in their ability to take a given patient because of their clinical sophistication or just their capacity, and so how much choice folks experience in practice, I think, is something that we kind of wrestle with.

MR. HACKBARTH: I had lost sight of that, Herb, so thanks for that. But I would imagine that most Medicare beneficiaries, when they get their list of the five or ten or whatever the number of agencies is, they say, well, which one should I go to, and whatever they're advised to use by the hospital discharge planner is the one they end up using.

DR. REDBERG: Do you think any of them use Home Health Compare?

MR. CHRISTMAN: It's available. I don't get the

sense that it -- we haven't talked about this too much, but when I talk with folks about the factors that end up getting weighed, it doesn't come up very often that consumers are taking a hard -- I guess the aside I would say on Home Health Compare is when they were building those measures, they convened a panel of consumers to say, you know, do these measures make sense to you, and the report explaining how those focus panels went said that a lot of the presentation was taken up by the presenters explaining what home health was. So I think that that's sort of the challenge, is people -- I think it's hard for people, unless you're like me and you spend a lot of time with it, but for consumers, they don't really understand what the parameters of the service are until they actually start to use it. So I think that that's a challenge when they're looking at that list of providers.

DR. MARK MILLER: I'm sorry. Just beyond the hypothesis and the analysis, I mean, maybe the policy -- and this is thinking off the top of my head -- the policy we start to think about is if there is some alignment, and we define how that's aligned, I'm in an ACO, then you are relieved from certain pressures in fee-for-service. So

there is a readmission penalty. But if you go into an ACO, no readmission penalty, that type of thing. And so you've got a push-pull going both in fee-for-service and ACO. And I'm making all this up on the spot, so I've have to think it through a lot more with Evan, but that kind of thought. And maybe in addition to your thought, we could come back with something like that.

DR. NERENZ: Yeah, a couple quick questions about the OASIS instrument that you mentioned. I think you said it was required at the beginning and end of each episode, is that correct? And is that true without exception at all, any episode, any kind --

MR. CHRISTMAN: In Medicare, yes.

DR. NERENZ: In Medicare.

MR. CHRISTMAN: Now, the wrinkle is, and we talked a little about this last month, is that it's -- the agency is required to complete it, but they're only required to send -- of all the patients they serve, if they send one of those to Medicare, report that data, then they have met all their reporting obligations. So the data is collected. Whether we always have complete information for the national statistics we support, but what we report is a second issue.

DR. NERENZ: Okay. I'm mainly just interested in the requirement to collect. Now, I was in a meeting recently, somebody made reference to a 30-some-page intake form. Is that plausibly referring to OASIS --

MR. CHRISTMAN: It quite possibly is, yes.

DR. NERENZ: Thank you.

MR. BUTLER: So on this one, and you have more data in the chapter on the efficient agencies. Now, this is sort of different from the other sector. You've got 12,000. If you look at, like, inpatient rehab or LTCHs or dialysis, there's consolidation and some fairly big for-profit companies, and there's very little of -- this is kind of a cottage business. So when I look at this, the only thing I see is the -- I see that it can be done, but the only characteristic really is the size, 29 percent bigger, which isn't really big.

So I'd like to learn a little bit more. Are these located in certain geographic areas? Do they -- what else do we know about these high performers besides that they're slightly bigger, would be helpful.

MR. KUHN: Yeah. I was reading one of the letters that the Commission received, and this one was from the

Partnership for Quality Home Health Care, and that's a little bit some of the data that George was talking about. So they mention these five States, California, Texas, Florida, Illinois, and Ohio, and there were three kind of interesting facts in here about those five States. One, that more than half of all home health agencies are located in just those five States; that about 83 percent of the new providers in this space are in those five States; and that basically nearly half of all Medicare home health payments are in those five States.

So I guess I was interested in your response to George's question, Mark, and I think that was real helpful for me. But I guess the question is, as we look at the overall margins across the country, do we see some differentiation in margins? Do we see them -- are they higher in these five States versus others, because I think about -- Tom has raised it many, many times here, and he talks about South Dakota and the margins just aren't there in that State. So, obviously, we're looking at this margin rate that we're projecting of 11.8 percent. Is that pretty standardized across the country, or do we see higher margins in these States and then lower margins in States like where

Tom's from?

MR. CHRISTMAN: It's been a while since I've looked at the State by State level. There is some variation among the States, and I'm reaching deep into my memory banks here, but generally, they're almost -- even the low ones at the State level are generally still double-digits, cracking ten percent. You know, when you look at the variation across the States, you have to keep -- there's two pieces we haven't really ever disentangled that can drive some of that, and whether there are some inadequacies and problems in what the wage index is doing, because that's going to be a big difference among those areas. And the other thing is that we have observed that agencies with higher therapy delivery, that deliver more therapy episodes, generally do better. So you have to think about the differences and sort of those factors and how they explain some of the spread that you see.

[Off microphone discussion.]

DR. DEAN: I was interested in the written material, the issue of the improvement standard and the fact that is that really not applicable anymore? I mean, it certainly has been something we've relied on a lot, not so

much for home health, because we don't have any home health --

[Laughter.]

DR. DEAN: -- but in other areas. Is that truly not going to be something that's usable now?

MR. CHRISTMAN: That's the court settlement, that the standard effectively is going away.

DR. DEAN: Because that's going to complicate things significantly in terms of determining where an end point for some of this stuff is, but --

MR. CHRISTMAN: Yeah. There's still a lot to be -- you know, we're kind of in this -- as I understand it, we're in a current kind of limbo where they've said -- they're stopped enforcing the improvement standard, but they haven't put out refined guidance that kind of gives people an idea of whether there are any other secondary changes that go along with this. In the future, what's going to apply generally for home health is whether you are homebound and whether you have a skilled need. Those are sort of the two first primary checkpoints you have to clear and the improvement standard is gone. So, certainly, that could open the door for people to stay longer or for people who

otherwise wouldn't have qualified to get in.

DR. DEAN: Okay. Another question, I guess I never really have understood rebasing, but if that were to take place, the problem with the facilities that the agency that I'm familiar with is low volume and lots of travel and that makes them financially non-viable. And just an aside, I don't think there's been a new home health agency in South Dakota in probably five years. I could be wrong, but if it is, it's only one or two. Does rebasing address any of those issues?

MR. CHRISTMAN: I mean, no.

DR. DEAN: Okay.

MR. CHRISTMAN: But I guess another way to think about it is if there are areas that truly have access problems, Medicare already has a rural add-on, and --

DR. DEAN: But even with that, we have lost agencies.

MR. CHRISTMAN: And I guess the next point I was going to go to, Tom, is that Medicare, three percent rural add-on, it's a couple hundred million dollars a year. But because it's targeted at the episode level, rural areas that have more episodes get more of an add-on payment. Seventy

percent of the add-on dollars flow to rural counties with utilization above the national average.

DR. DEAN: Yeah. Okay.

MR. CHRISTMAN: So Medicare -- it set aside money to address the type of situations you're talking about, and it may be thin gruel for the real problems you see in your area, but I'm afraid that I kind of see the other side of this, that there's a lot going to areas that probably don't need it.

DR. DEAN: Well, and I would completely agree, I mean, and I think it's clear as we dig through a lot of this stuff that the rural-urban cut is not the useful cut. Well, I mean, we could have a long discussion about that. But that clearly -- I mean, it's a distinction we've relied on a lot, but it clearly doesn't tell us what we need to know.

MR. HACKBARTH: This is another good illustration of the point that we've now discussed several times recently about the importance of good targeting and just across-the-board rural add-ons, especially, paid the way. Evan describes it as an add-on to each episode, may not be very effective targeting for the unusual situations that you're most concerned about, Tom.

MR. KUHN: If I could just follow on -- I'm sorry, Tom, to get on your time here, but the LUPA adjustment, does that play much in terms of areas that Tom is talking about? And if it does, when is the last time that particular adjustment was really looked at in detail to make sure that it's properly targeted, as well?

DR. DEAN: And then you could tell me what it is. I didn't understand it.

MR. HACKBARTH: Yeah. That's the low utilization adjustment. So if -- it's at five visits?

MR. CHRISTMAN: [Off microphone.] Fewer than five.

MR. HACKBARTH: Fewer than five visits, then Medicare doesn't pay it on an episode basis but on a per visit basis.

MR. CHRISTMAN: Overall, they are about ten to 15 percent of episodes, but because the payments are so low, they're, like, one percent of the money. I would be surprised if that is a huge factor in the differences, or the issues that rural areas experience. Certainly, they may experience losses on those episodes because they are small and the payments are very low, but if you fixed that, you

would probably still have -- 99 percent of the money in the system is for the regular episodes, not the LUPAs.

DR. MARK MILLER: [Off microphone.] Can I just make one point? You know, Tom, one appeal I would make to you, and given your past and the positions that you've held in the past, is if you see clearly now this notion just as illustrated, and we talked extensively in the rural report that it isn't about money, you know, to every rural. It's about targeting what problem. I mean, that's a message that you could carry into the rural community, because I've got to tell you, it's not punching through.

DR. DEAN: [Off microphone.]

DR. MARK MILLER: I just -- you know, every little bit. That's all I'm saying.

DR. COOMBS: I was just curious, have any of the health agencies expressed to you hurdles about being in a bundled payment or global payment?

MR. CHRISTMAN: You know, I've had mostly informal conversations with them about this, and I would say that, you know, similar to all providers, with numerous reform efforts underway, they see both threats and opportunities and are trying to think about where they fit in. And I

certainly do detect an eagerness in those areas where they think they can improve care, they want to be a part of it. But as other folks have mentioned, some of these models, you know, change their markets in ways that there may be an exclusive provider for, or exclusive home health agency for a given hospital, and you could understand how that might make them nervous.

DR. REDBERG: I just have a comment, so I'll --

MR. ARMSTRONG: What are the capital requirements for home health agency, and what would that be one of our criteria?

MR. CHRISTMAN: Yes. This is less capital intensive than other sectors. I mean, certainly, they want to have cash on hand. I think the big things that people mention are back office systems, ID, and things like that. There's actually, relative to -- a lot of home health agencies, because of the OASIS and the electronic data requirements --

MR. ARMSTRONG: Information technology.

MR. CHRISTMAN: -- they've gone to electronic point of care and things like that. And in some ways, I think there are some agencies who are probably leaders

relative to any category or provider and use elaborate back-end systems to manage care, to move all the required information they have to move. You know, for them, it's a way of ensuring that their records are both portable and secure when it works out.

MR. ARMSTRONG: I don't know of a proposal, but I just wonder if that's really that helpful of a criteria for us. I know it's our standard, but it's just worth considering.

And then another question, I don't know how to frame it exactly, but there's a lot of talk now about the idea of a hospital at home kind of a program, which, I think generally speaking, is just an expansion of the use of home health services to more acutely ill patients, is what I'm assuming. So how does the payment structure that exists today that we're talking about tweaking encourage or discourage that kind of use of home health?

MR. CHRISTMAN: Well, I guess what I would say is to the extent that somebody -- that you want to run a hospital at home program and that those patients also meet Medicare's coverage standards, you could run a hospital at home program inside of the current payment system, though

it's not deliberately set up to accommodate it. I think the catch is when people want to use new models of care, probably the skilled care requirement is relatively easy to meet if they've got a decent model. But I think that the hitch people run into is the homebound point, you know.

So in the hospital at home program, you could say, you know, I want to provide you this expanded basket of services, case management and social worker and aide services, but in order to do that, you can't leave the home very often. And for some beneficiaries who are at that point functionally, this could be -- that could work out fine. But there might be beneficiaries that benefit from such a program who don't meet the homebound requirement. You would not be able to do it.

MR. ARMSTRONG: So there are aspects of the payment policy that exist that would discourage the advancement of that kind of a --

MR. CHRISTMAN: Not permit it, yeah.

MR. ARMSTRONG: Yeah. Thanks.

MR. HACKBARTH: So if -- where I thought you might be going, Scott, is that with the terminology, hospital in home means to me is a home health agency with really robust

capabilities of some sort. And one of our challenges in this broad area of post-acute care is that home health agencies may differ in their capabilities. Skilled nursing facilities may differ in their capabilities. And, in part, the variation is a function of what the other resources are in the community. So in a community that doesn't have any long-term care hospitals, you might have SNFs, for example, and maybe home health that look very different and have more robust capabilities because they're filling a void that in other communities is filled by a separate institutional type.

None of our payment systems recognize these differences in capabilities for post-acute providers, and so one path you could go is to say, well, if the idea of hospital at home takes off, we've got to do that outside, or at least as a separate adjunct to the home health payment system. And then we get still another type of silo. Another approach is to say that if there are care delivery innovations of that sort, we're not going to build still more silos and separate payment systems. They need to happen under the umbrella payment systems, like ACOs. It may be a very good idea. It may make great sense for a

hospital to invest in those capabilities in partnership with a home health agency, but we can't proliferate unique payment systems for all of the innovations that might occur.

MR. ARMSTRONG: That was really a second round question or comment, but I just don't know if it's good or bad if there are more services, or if the volume increase has leveled off, whether that's good or bad. And then inside of that, this variation in what's -- I run a huge home health agency and we're pushing very hard to create this hospital at home kind of a program, but I just don't -- within this payment structure, I just -- I don't -- the incentives are very -- I just don't think -- anyway --

MR. HACKBARTH: Yeah. I confess that I've sometimes wondered whether it ever made sense for Medicare to have a separate payment system for home health, or perhaps, alternatively, we should have only paid for home health services in combination with other services, in combination with hospital or in combination with a physician that has ongoing responsibility for coordinating care. To have it as a separate silo -- Mike?

DR. CHERNEW: That horse has left the barn. We're trying to get it --

MR. HACKBARTH: Yeah. That horse has left the barn, yes.

[Laughter.]

DR. CHERNEW: I was going to just comment about the --

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

DR. CHERNEW: I wanted to comment on the capital requirement portion of what Scott said, and this is -- I'm going to say this probably as a comment, but it's really a question to make sure what I said is right. I think the access to capital section is really just used loosely and it's a place where, in terms of payment adequacy, we look at, is there entry into the industry and is there not. So while capital is relevant more so for some than others, it's also the place where we look at are home agencies entering or not.

And so the last bullet on that Slide 11 captures something that's not really access to capital per se, even if you needed capital. It's capturing a broader point that there's a lot of entry into this industry, and that says something, capital or not, about the adequacy of payment.

MR. ARMSTRONG: Well, not to interrupt this round of our work, but maybe next year we ought to think about whether there's a different label for it.

DR. HOADLEY: I just wanted to pick up where Tom started, on the improvement standard question, and just really wondering kind of the same question I asked on SNFs. Is there anything about what we've said already in terms of rebasing that could anticipate -- I mean, maybe this is something you can't even think about until next year, but is there anything that can anticipate sort of being ready for changes that the elimination of the improvement standard can bring.

MR. CHRISTMAN: I guess the, you know, the work we've done in SNF is actually somewhat parallel to home health, as well. I mean, we want to make -- we're currently concerned that the payment system is set, in part, based on the types of and amount of visits people provide. When those new patients come in, we want to ensure they get services that are appropriate based on their characteristics and not the incentives. So that would be one thing.

I think the second thing is, you know, we're always worried about the appropriateness of services in this

sector, and having rates that are, on average, so far in excess of costs, you worry that that creates an incentive -- sort of piles on. The improvement standard will liberalize things and people who are disproportionately focused on that margin may see that as more of an opportunity than it really should be.

But I think the challenge, Jack, is we don't know how many people are going to come in off the street as a result of this, and that's really, I think, a question. It may be significant, but we'll see what happens and maybe we'll have a better sense once the new guidance rolls out. But we won't really see until agencies are implementing it and claims are getting adjudicated how this is kind of shaking out.

DR. HOADLEY: I think anything we can say to sort of just flag this as an issue is probably useful. And, of course, it's going to get us potentially further away from the sort of post-acute framework that we've been also talking about because these are people who are probably farther down the line from the acute care you talked about before. You know, if there's a bunch of episodes, it maybe ultimately started with acute care, but they've gone on and

continued. Well, this could just keep that going further, as well, as people who never had an acute care link.

DR. NAYLOR: So, briefly, I -- this is in reference to the Chairman's recommendation, and I am concerned about action on this recommendation at this point in our time, even though I supported it last year. So I think that really effective and efficient home health can help move high-risk, vulnerable Medicare beneficiaries to lower risk if effectively applied, and I would be -- and we have so much going on right now. We have hospitals with rehospitalization penalties that just started in October that are going to change this year. We have community-based care transitions program that are trying desperately to figure out how to link hospitals with the efficient, effective home care and community-based organizations.

And so I would just want to make sure that whatever we're doing in terms of update really doesn't in any way interfere with the kind -- you know, what has been unleashed in terms of care, system redesign. The Accountable Care Organizations are looking for the kinds of service delivery in the home.

So I'm wondering whether or not PPACA's

recommendations to start something in 2014 would give us a little bit more time to look at -- and they're talking about 3.5 percent reductions for four years -- would give us a little bit more time to see how things are shaking out.

I do think that, ultimately, this should be always about performance, and performance of a system that's aligned with people's needs over the most vulnerable times.

MR. HACKBARTH: Mary, not to be argumentative, I want to just explore this with you for a second. So in defense of home health payments, the argument is often made that good home health is really important, and it can be very good for patients and it can save money, too. And I want to be clear, I'm a believer. I accept that and I think it could even play a larger role in the future.

The hang-up for me has been how does just paying above costs for every episode of home health actually advance the goal of better home health, because persistently high margins, what that means is they're not reinvesting the money in improving home health. If they reinvest it, then the costs would go up and the payments would come in line with costs. We're paying more and the money is being taken out of the system to go someplace else.

And so I'm not sure I see the connection between maintaining high levels of payment, way above costs, and getting to the more robust home health system that you and I, I think, probably jointly seek.

DR. NAYLOR: I'm not sure that -- I mean, I totally agree with your statement and I don't know enough now to know -- I mean, I'm just expressing what I'm concerned about, that we would implement a recommendation that has to do with rebasing home health rates and eliminating the annual update, would it in any way -- all I want to know is, would it in any way affect those visiting nurse services or others that are doing the most important things for the vulnerable people, and in some ways then negatively affect not just the beneficiaries, but the program. I mean, this is about reducing hospitalizations, rehospitalizations, and everybody is on board with that right now and I just want to make sure that we don't -- that whatever recommendation is aligned with that. So I'm not sure that I won't support this. I'm looking forward to the extra work.

DR. HALL: Well, I think we -- I would speak in support of this, if for no other reason than we have to keep

the infrastructure that's invested in home health care going. But I hesitate to say this, sitting on the left hand of the maven of transitions in the United States, but I think we should put in an additional recommendation that maybe it's time to start looking at the advisability or the -- yeah, the advisability of having a much closer alignment between home health care agencies and the health care systems that they serve. Maybe the free enterprise system here is really working against us in the modern health care system and where everything else is going. And so maybe there could be a two-pronged approach here.

MR. GEORGE MILLER: I share the comments that have been made, particularly with strengthening the home health component to be part of the system. I like that notion and the comments that have been made, particularly what I mentioned earlier and what Herb was reading from. We have -- unfortunately, we have a system that is little capital to get in and there's just five States that have driven half of the aberrant behavior, or appears to be the aberrant behavior. So coupling within the system bundled payments or ACO payments makes sense as we try to transition from silos to comprehensive care.

DR. SAMITT: I think you know where I am on this. I support the recommendation, although I think we, as others have said, we need a bridge between the silos and it doesn't feel like there is one to home health care at this point. And what the challenging part of it is that the payment recommendation doesn't sit within the home health care world. It may sit in some of the other realms to engage home health. So I think we'll need to collectively put some more thought around it.

The only other thing, though, that was discussed that troubles me is the rural add-on, and I do wonder whether we need to make a policy recommendation regarding linking the rural add-on only in the setting of low volume, and maybe there's a redirection of resources to support that and maybe that should be a slight modification.

DR. NERENZ: I'm basically okay with the recommendation. The only additional comment I'd make is that I would like to seek opportunities here, if it's appropriate to also comment on the underlying cost for which the payment is supposed to be adequate, and maybe this comes in this report, maybe it comes elsewhere, but let me go back to my OASIS question, which is where I was trying to get

here.

A couple of years ago, we were trying to work on a very -- a program on preventing readmissions related to falls, and in that planning in the context of an integrated system, we wanted a really tight, really lean home health component, three or four visits, but focused very tightly on falls prevention. The requirement to do this intake assessment was a deal killer that unraveled the whole thing, because in order to receive Medicare payment for this component, this elaborate assessment had to be done, which, frankly, in this situation was not needed.

Now, we could debate this over dinner or something, but the general point would be when we talk about the adequacy of payment, we're talking about the adequacy of payment to cover a set of costs, and my point is that not all those costs are truly value-added for the beneficiary. Here's an example. I think we see it in some of the other things we talk about. So at least, as a general point, I'd say when we make our statement about payment adequacy, I'd like also, if possible, to accompany it with things about how the underlying costs could conceivably be reduced.

MR. HACKBARTH: Yeah. Is there anything you

wanted to say about OASIS and --

MR. CHRISTMAN: I think that the way the home health -- I could see how that would unfold the way you laid it out, David. I think that the home health payment -- the home health system, I think -- and this came up in conversation with Scott -- it's strength is you can do a variety of different things, different business models under the current home health benefit. There's a lot of flexibility. But if you want to do a relatively simple, focused three-four visit, yeah, that a lot of the -- a full-blown assessment where they're going to do -- trying to build sort of the clinical background to do a full case-managed 60 days worth of care is kind of overkill. When you want to do something relatively simple, it may not fit. And whether there's sort of a -- we've talked about this informally, whether there's sort of a low home health benefit that you could come up with has been something we've talked about informally.

DR. BAICKER: So, first of all, if that's what we're talking about over dinner, then I'm not coming.

[Laughter.]

DR. BAICKER: I think this --

DR. NERENZ: I just was not trying to belabor this discussion now.

[Laughter.]

DR. BAICKER: I think the reason that this is such a struggle for all of us is that home health really embodies a lot of the things that we see as shortcomings with the overall system that are hard to fix in this update siloed framework, and that's in part because there's huge heterogeneity of the benefits that accrue to somebody receiving these services, and along with that, there's a lot of preference-sensitive care consumption or there's really elastic demand, so that we think that there's a huge opportunity for these services to be dialed up or down based on the payment, yet they provide sometimes incredibly valuable benefit to the beneficiaries and sometimes a much lower benefit, and the question is how do we design -- how do we reform the payments to promote the higher value use and ensure access to that and discourage the other kind of use, and the answers have to come through a combination of changing the way the payments interact with other parts of the system, and we've talked about the hospitals and we've talked about their post-acute care and changing the way that

beneficiaries pay for those services and neither of those is really on the table right now for today's discussion.

So the recommendation looks good with those constraints, but those constraints are particularly binding and rankle particularly in this instance of care that has those features, and I think that's part of why we're all so uncomfortable with the current state of affairs.

MR. BUTLER: So I can support, and particularly because the cost of entry and exiting this business is not capital intensive, I am convinced that we could make adjustments to accommodate any unintended consequences of the rebasing.

DR. CHERNEW: Yeah. I also agree, and I would just say the other thing that makes this so hard is the heterogeneity in the providers. And every time there's a lot of heterogeneity in the providers, we always worry about what goes on, because we don't want to hurt some because we're trying to get average payments right one way or another, and that just makes it really hard. So I don't have much more to say about that beyond what's been said, so I'll just say I support the recommendation.

MR. KUHN: Yes, I support rerunning the

recommendation again. Just one quick question. In a previous meeting, we talked about the beginning work of rehospitalization, recommendation for home health overall. That is work we'll probably come back to in the spring, I assume?

MR. HACKBARTH: Readmission?

MR. KUHN: Readmission, yes, rehospitalization. So okay. So that won't be part of this, but as a subsequent conversation.

MR. HACKBARTH: [Off microphone.]

DR. MARK MILLER: May I try and link it to some of the comments of --

MR. KUHN: Yeah. I think that would be great. Thanks.

MS. UCCELLO: So I support the recommendation, and I'm also wondering whether it makes sense here to reiterate our recommendations regarding getting rid of the therapy thresholds and basing payments on the patient characteristics.

MR. HACKBARTH: I'm sorry, I didn't hear the, sort of the middle part. At least get to what?

MS. UCCELLO: Do we also want to reiterate our

recommendations regarding getting rid of the therapy thresholds?

DR. MARK MILLER: The PPS reforms.

MR. HACKBARTH: Oh, yeah.

DR. MARK MILLER: That's what she's talking about.

MR. HACKBARTH: Mm-hmm.

DR. MARK MILLER: We can -- I mean, this is a decision. We can certainly rerun the whole array of recommendations, if that's what you guys want to do.

MS. UCCELLO: I mean, I think, given all the concerns that everybody has, putting those aside, and I agree with those, it just seems that there is an increased urgency of -- given this is what we have to do, we need -- the increased urgency, I think, comes from the court's agreement and that this could be, you know, increased utilization, in general, of these services. And so it's more important to make sure the payments are right.

DR. DEAN: I guess I would share Mary's hesitation and Bill's comments about, you know, we somehow have to figure out a way to tie this very valuable service into the broader system, and we're obviously doing a pretty poor job of that right now.

It seems to me, as I was thinking about it, you know, this improvement standard is one challenge, although we sort of have two populations here. We have that group of people that are just coming out of the hospital, they need some help, they need to get back on their feet, they need some therapy, they need some strengthening, those things. They're limited in terms of how long they're going to be on the program. On the other hand, we have the people that I think Mary alluded to that have serious chronic disease that may well very legitimately and appropriately need this service for a very long time, and I think most likely you can justify that from a cost effective point of view if it really is focused and delivered to that limited group of people. But we haven't figured out quite how to do that.

I guess I struggle because, on one hand, we obviously have some margins here that are really bothersome. On the other hand, we also have, apparently, 25 percent of the agencies that are losing money. And somehow, we've got to figure out how to sort out which of those are really delivering a service and providing value and which of them are just taking money out of the Medicare program and I don't think we've figure out how to do that.

So maybe we can't -- I understand, we can't do it with this update mechanism. On the other hand, I think it does argue that we really need to at least in the text make sure that we try to send the message that this is a poorly targeted benefit right now.

MR. HACKBARTH: I think what we can do, and this goes back to Cori's suggestion, is that in both home health and skilled nursing, where we've recommended rebasing, we've also made a point of saying that the payments are currently maldistributed. And so we've coupled rebasing recommendations with improve the payment system and make it more accurate sort of recommendations. And what these comments suggest to me is continuing to couch rebasing in that form.

We've got two types of problems. The average level is too high, and then, second, the dollars are not well distributed. That may be a factor in some agencies losing money. I can't guarantee that, obviously, but it could be a factor. So agencies that are doing all the right things are just not getting paid adequately for it and so they end up losing money.

Alice.

DR. COOMBS: I support the recommendations. I was thinking about something that Bill said at the last meeting when we were discussing this very issue. I think that in the ICU, particularly, we actually have people who elect to go home and some of them are on bipaps, some of them are going to be vented in their living room. And so you almost have to, going forward, consider the different types of patients that are being treated and actually categorize them in, you know, like high-intensity, low-intensity, and I think we have an opportunity to do that going forward.

DR. REDBERG: I think, like others have said, home health care is a very valuable service when used appropriately, and so it's a shame, like for other things, that there are issues of fraud, waste, and abuse and other things that color and make it harder. But it does seem particularly that's accentuated by this kind of siloed fee-for-service model, and so all of the suggestions where it is bundled, where really the goal is to help our beneficiaries get better and feel better, which I think home health plays an important part, so if that's a bundled ACO or those sort of payment models would be a great way to handle it to incorporate it.

And just if OASIS is really 30 pages, I would consider that that's a little burdensome and onerous. I'm all for quality measurement, but that seems a bit much.

I support the Chairman's recommendations.

MR. ARMSTRONG: For the same reasons, I support the recommendations. I just would add that while I think, in the right system, investing even more aggressively in home health will offer a huge return in terms of overall health and total costs and so forth, I don't think we need to wait at all to conclude that the Medicare program is overpaying on a per unit of service basis for these services right now.

DR. HOADLEY: Yeah. I'm supportive of the direction and really sort of endorse these various comments about anything we can say about some of these revisions or concerns going on would be good, as well as making -- it would be useful to be very clear in the report how this relates to what's already called for in the Affordable Care Act. Just make sure it's clear how this overlays with that.

MR. HACKBARTH: So when Carol began the discussion of skilled nursing and home health, she gave a brief presentation, introduction to Medicare payment updates for

the post-acute sectors, and I think in that sounded some important themes that have now echoed again through this conversation.

Is the plan, Mark, when we get to producing the chapters for March, to have text that is a prelude to the chapters on home health and SNF and other post-acute providers talking about some of these issues? I know we've done that before, and we could even pirate some of the things that we've written before. But I really think that's important context for talking about these payment systems.

DR. MARK MILLER: It is the plan now.

[Laughter.]

MR. HACKBARTH: Oh, good. I'm glad to hear that. You're always ahead of me.

DR. MARK MILLER: I'm looking right at Carol. Yes.

MR. HACKBARTH: Yeah. So we'll do that.

You know, I'm going to beat the payment reform drum one last time. We and many others talk so much about how we need to move away from fee-for-service, and nine times out of ten, the point that is emphasized there is that fee-for-service creates all the wrong incentives, the

incentives for increased volume and intensity and not for value and doing better things for patients. And, of course, I agree with that.

But on my list of problems with fee-for-service, almost as high as that is that the fee-for-service system, especially as operationalized through these silos, a problem just as big is that it impedes the free flow of resources to where they can do the best thing for patients. It creates boundaries. It creates seams. It creates obstacles in terms of rules and regulatory requirements. And we would be much better off if we had clinicians decide -- clinicians who know the patient, know what the needs are, matching them with appropriate home care, for example, potentially the home hospital if that works for the patient.

We've got to get beyond this siloed payment system in the interest of quality for patients. Forget all the incentives about volume and all that stuff. We've got to get the resources flowing more freely to meet patient needs. So that's my speech for today.

Thank you, Evan. We appreciate your good work on this.

Now, we'll have our public comment period for

anybody who has had the endurance to stay with us.

[No response.]

MR. HACKBARTH: Okay. Seeing none, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 5:52 p.m., the proceedings were recessed, to resume at 8:30 a.m. on Friday, December 7, 2012.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 7, 2012
8:32 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:32 a.m.]

MR. HACKBARTH: Good morning.

So this morning, we will conclude our consideration of draft recommendations on updates.

For the audience, let me just say a few words about the context. These are draft recommendations that we'll be discussing today, draft recommendations that I am offering for consideration by the Commission. Based on the discussion today and conversations I have with individual commissioners between now and the January meeting, we will formulate final recommendations for a vote in January.

Under the statute that created MedPAC, our task is to advise the Congress on payment rates that are consistent with the efficient delivery of services after considering the effect of our recommendations on the Federal budget. Ultimately, we want to assure that our proposed rates do not impede access to quality care for Medicare beneficiaries.

Those of you who have followed our work in the past know that we use a multi-part payment adequacy framework, which you will see in evidence as we go through each of the presentations this morning. Our approach to considering the updates is that we begin with the current

rates, the prevailing rates, and then ask the question whether there is evidence that would justify either an increase or decrease in the prevailing rate.

In other words, we do not use an approach that says the starting point is market basket minus productivity, or whatever the relevant measure is in the Medicare statute. Instead, we start with the current rate and ask whether it should be increased or decreased based on the available payment adequacy evidence.

This year, the sequester creates different questions than we usually face about payment rates, and so we're going to take a minute and explain how the sequester plays into the consideration of payment updates.

Kate?

MS. BLONIARZ: So the Medicare sequester starts in February 2013 and cuts 2 percent from nearly all provider payments. This slide shows how that works.

The sector receives a statutory update each June and the yellow line shows the payment amount in the absence of the sequester. The dashed green line shows their payment amount when the sequester begins in February 2013.

The updates the Commission is considering today

are based on the yellow line. They are updates to the base rate.

The presence of the sequester will affect the savings estimates for the Commission's recommendations. In the first example, a sector has a base rate of $100 in 2013 and the statutory update of 1 percent. In 2014, their payments increase by $1 for the update and decrease by $2 for the sequester, to $99. If the Commission recommends a 1 percent update for 2014, this would update in a payment amount of $101. Compared with the sequester baseline, the Commission's recommendation would have a cost.

The second example shows a sector with a base rate, again, of $100 and a statutory update of 1 percent. Again, the sequestered amount for 2014 is $99. But for this sector, the Commission's recommendation is a negative 2 percent update, resulting in a payment rate of $98. Compared with the sequester baseline, the Commission's recommendation has a cost.

So the recommendations may result in savings or costs relative to the sequester baseline, based on what the statutory update is and what the update recommendations are.

MR. HACKBARTH: Thanks Kate.

So let’s now turn to inpatient rehabilitation facilities.

MS. SADOWNIK: Good morning. In this presentation, we will discuss the adequacy of Medicare payments to inpatient rehabilitation facilities, or IRFs. I will present data on a range of indicators of payment adequacy and then review a Chairman's draft recommendation for payment rates for fiscal year 2014.

IRFs provide intensive rehabilitation services, such as physical and occupational therapy and rehabilitation nursing, to patients after an injury, illness, or surgery. IRFs may be specialized units within an acute-care hospital, or they may be free-standing hospitals. Hospital-based IRFs represent 20 percent of facilities, but they account for only 55 percent of Medicare IRF discharges. Relatively few Medicare beneficiaries use IRFs because patients must be able to tolerate the intensive therapy. Nevertheless, Medicare fee-for-service is the principal payer for IRF services, accounting for 62 percent of total cases in 2011 and almost $6.5 billion in spending. Since 2002, IRFs have been paid on a per discharge basis where rates vary based on patients' conditions and severity of illness, as well as on

certain facility characteristics.

IRF patients must require at least two types of therapy, one of which must be physical or occupational therapy, and patients must be able to tolerate and reasonably be expected to benefit from three hours of therapy per day for at least five days a week. To qualify as an IRF, facilities must meet certain criteria. In addition to meeting the Medicare conditions of participation for acute-care hospitals, IRFs must have a medical director of rehabilitation on a full-time basis, have a preadmission screening process for patients, and use a coordinated interdisciplinary team approach led by a rehabilitation physician. Rehab physicians must be involved in pre-admission screening, post-admission evaluation, and development of individualized care plans.

In addition, IRFs must meet a compliance threshold which stipulates that no fewer than 60 percent of all patients must have at least one of 13 conditions, although determining compliance can be complex. Because IRFs are a more costly setting for post-acute care (compared to SNFs and home health), CMS developed the compliance threshold to ensure that IRFs treat patients who are appropriate for this

setting. Trends in volume and patient mix have been sensitive to policy changes in compliance criteria. After the compliance threshold was renewed at 75 percent in 2004, IRF volume, occupancy rates, and the number of beds declined. The share of cases with conditions that count towards the compliance threshold increased, and the share of major joint replacement cases, in particular, declined. We saw a large shift in the post-acute care settings for major joint replacements. Hospital discharges shifted away from IRFs for these cases and to home health agencies and SNFs. In 2007, the compliance threshold was capped at 60 percent, and the industry began to stabilize.

We will use the same framework to analyze payment adequacy for IRFs as for the other sectors, including access to care, quality of care, access to capital, and payments and costs.

Let's start with access to care. I will review the supply of facilities and beds, as well as occupancy rates and volume of services. With respect to supply, as you can see here, there were 1,165 IRFs in 2011. Between 2010 and 2011, the total number decreased by 14 facilities, or a little more than 1 percent. The total number of IRFs

has declined every year since 2005, which reflects a trend of hospital-based facilities leaving the market and the number of free-standing facilities slowly increasing. The supply of IRF beds largely follows this trend too, although the number of beds in free-standing facilities also declined very slightly in 2011. Note that while free-standing facilities make up only 20 percent of IRF facilities, they represent about 40 percent of all IRF beds, due to the higher average bed size per facility.

Occupancy rates represent another measure of IRFs' capacity to serve patients. In 2011, occupancy rates rose modestly to 63.3 percent. Although rates fell slightly in 2010, they have risen most years after 2007. Occupancy rates were higher in free-standing IRFs than in hospital-based IRFs and higher for IRFs in urban areas than those in rural areas. These occupancy rates suggest that capacity is adequate to handle current demand and can likely accommodate future increases.

Now that we've reviewed capacity, let's turn to trends in volume as well as payment. This chart presents the number of fee-for-service cases, payment per case, and total fee-for-service spending. While the number of cases

dropped in 2010, cases rebounded in 2011 by 3.3 percent. Note that volume has been increasing even as the number of beds has decreased, suggesting that beneficiaries are not losing access to services overall.

Fee-for-service spending totaled an estimated $6.46 billion in 2011, an increase of 5.2 percent. The sharp increase in spending reflects the growth in number of cases and in payment per case, which increased by 1.8 percent in 2011. Factors that impact the growth in payment per case include a 2.25-percent update to the base rates in 2011, a 0.9-percent decrease in outlier payments, and 0.3-percent increase in patient severity.

Turning to quality of care, we worked with RAND to measure IRF quality through five risk-adjusted measures that cover functional improvement, where the beneficiary is discharged to, and readmissions. Mostly we see stability in IRF industry performance from 2009 to 2010. The amount of functional improvement (or FIM gain) decreased moderately. While the rates of being discharged back to the community got very slightly better, rates of admission to a SNF within 30 days after discharge got very slightly worse. We had two measures of acute hospital readmissions: being discharged

directly back to the hospital and being readmitted within 30 days after discharge to the community. On both, we see essentially no change.

Access to capital is another measure of payment adequacy. Hospital-based units have access to capital through their parent institution, and as we heard during the inpatient hospital presentation yesterday, hospitals have overall maintained reasonable levels of access to capital in 2011. We have also seen a continuing industry focus on shifting capacity to the outpatient setting. As for free-standing IRFs, we review access to credit for one major national chain, which shows that their ability to borrow has increased, largely due to improving credit markets and the chain's strong operating performance. Besides this chain, most other free-standing facilities are independent or smaller chains with only a few providers, and it is less clear how much access to capital these providers have.

I will now go over IRF margins for 2011 and then discuss factors that drive these margins. Overall margins were 9.6 percent in 2011, up from 8.7 percent in 2010. We see that margins vary substantially between hospital-based and free-standing IRFs. Free-standing IRFs had margins of

almost 23 percent in 2011. They represent about 44 percent of Medicare spending. In contrast, hospital-based IRFs had margins of negative 0.8 percent, and their average margins have been decreasing since 2009, while margins for free-standing facilities have been increasing. Margins in for-profit facilities were about 21 percent, while nonprofit facilities had margins of 2 percent. Hospital-based facilities that were for-profit had higher average margins than hospital-based facilities that were nonprofit.

On the next slides, I will discuss some possible reasons for the differences in margins between hospital-based and free-standing IRFs.

As context for this discussion, recall that although hospital-based IRFs constitute 80 percent of all IRF facilities, they account for a much smaller share of Medicare discharges, about 55 percent, due to smaller bed sizes and lower occupancy rates. Therefore, 45 percent of Medicare IRF discharges are in free-standing facilities that have an average of 23-percent margins.

Hospital-based IRFs have higher costs than free-standing IRFs. We did not find that their patients are sicker. Instead, reasons include that hospital-based IRFs

tend to have fewer beds and lower occupancy rates, which keep them from fully capitalizing on the economies of scale of the more efficient free-standing facilities. Among hospital-based IRFs, both direct and indirect costs were higher than in free-standing IRFs. In 2010, direct costs per case were 30 percent higher in hospital-based IRFs and indirect costs per case were 11 percent higher.

However, based on 2010 data, even though Medicare margins for hospital-based IRFs are below zero, on average the IRF units are able to cover their direct costs. The direct cost margin, which is a Medicare margin that is calculated using only direct costs, was 34 percent in 2010 for hospital-based IRFs. In addition, overall Medicare margins for acute hospitals are about two percentage points higher for acute hospitals that have an IRF unit than for those that do not have an IRF. These data indicate that IRF units are able to cover their direct costs and financially contribute to their parent hospital.

As we have seen, aggregate Medicare margins for IRFs in 2011 were 9.6 percent. To project the aggregate Medicare margin for 2013, we modeled the policy changes driving payment rates for 2012 and 2013. We project that

Medicare margins for 2013 will be 8.3 percent. To the extent that IRFs restrain their cost growth, the 2013 margin could be higher than we have projected.

In summary, our indicators of Medicare payment adequacy for IRFs are positive. Despite the overall supply of IRFs decreasingly slightly, volume has increased and excess capacity in occupancy rates remain, suggesting that capacity remains adequate to meet demand. Margins average 23 percent for the sector of the industry that tends to operate more efficiently. Finally, risk-adjusted quality of care remains stable, and access to credit appears adequate for both hospital-based and free-standing IRFs. We project that 2013 aggregate Medicare margins will be approximately 8.3 percent.

The Chairman's draft recommendation for your review is: The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2014.

On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the 2013 payment rate. Note that this recommendation repeats the one we recommended last year. We

estimate that this recommendation will decrease federal program spending relative to current law. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressure on some providers, but overall we expect a minimal effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries.

This concludes the presentation, and Craig and I welcome any questions.

MR. HACKBARTH: Thank you, Sara.

Could you put up Slide 10, please? So we have a picture here where there's a significant difference between the margins of the free-standing and hospital-based facilities. For the new Commissioners, people may have picked up that in some areas, like home health and skilled nursing facilities, we just focus on the free-standing facility margins and have a payment update based on that. Here we've got a combination of hospital-based facilities and free-standing, and there's a significant difference in the financial performance between the two. So it may just be worthwhile walking through why hospital-based are combined with free-standing here and not elsewhere.

DR. MARK MILLER: And I'll start off because he warned me he was going to ask this question and he didn't warn you.

[Laughter.]

DR. MARK MILLER: So I'm going to tell a few jokes. While I'm doing that, get your thoughts together.

This is a conversation we had a number of years ago when we sort of moved into this space because we hadn't -- there was a point at which we came up to IRFs. And there were a few reasons that we did this. The first -- and this is pointed out in the analysis -- is that, unlike the other providers that Glenn mentioned, the hospital-based represents a much more significant proportion of what's going on here; whereas, in the other places it's, you know, 5 and 10 and 15 percent, those types of things. And so clearly the model has become dominated by a free-standing; whereas, here the model is not dominated by that.

The other thing that we did, because this was a concern, is how the allocation works in a hospital setting, and that has always been a concern of pulling them in. And some of it was historical and sort of when IRFs came along and that type of thing. But when we looked at that -- and,

Craig, this is where I'm trying to start to tap the memory banks -- there wasn't as much indication of allocation issues here. And so we also felt like, unlike where you find these stark differences in, you know, indirects in between the hospital-based SNF and a free-standing SNF, we didn't quite find the same patterns here, which also made us a bit more comfortable saying these things are, you know, okay to put together. And what really seems to drive the differences, which you said very clearly, Sara, was there really seems to be more volume occupancy issue on the hospital-based as opposed to a different model of care. That's my rough recollection of what the hell happened several years ago.

MR. LISK: You got it right.

DR. MARK MILLER: No kidding?

MR. LISK: Yeah, you got it exactly right.

DR. MARK MILLER: Note the surprise in his voice.

[Laughter.]

MR. HACKBARTH: Let me ask another question, Sara. This is for Sara. This isn't for you.

DR. MARK MILLER: I'm tapped out. I've got to go lay down.

MR. HACKBARTH: So could you put up Slide 8? The FIM gain number, as you point out in the paper, that's a 15-percent decline. You know, yesterday we looked at some quality numbers, trend numbers that, you know, were like flat. Here, a 15-percent change in a single year seems like a pretty significant move. You sort of didn't spend much time on that in either the paper or the presentation. What am I missing here?

MS. SADOWNIK: Yeah, and it's also worth noting that, you know, while the case mix increased very marginally between the two years, you know, we're not looking at really a difference in case mix that's driving the difference as opposed to maybe in previous years.

You know, it's interesting that there was more of a change in FIM gain than in the other measures that we're looking at. I would say that it's worth keeping in mind with FIM gain that this is out of a 100-point scale, so, you know, the difference on that large of a scale may not be as stark as the numbers themselves.

MR. HACKBARTH: Okay. So let's see. Scott, do you want to lead off with clarifying questions?

MR. ARMSTRONG: Just one. The IRFs in hospitals,

do they have to be physically a separate unit, or can they just be some number of beds designed in a particular part of the hospital?

MR. LISK: I believe that they're physically -- they're a specific unit within the hospital when they're free-standing, so it's designated units. They have the space designated in terms of -- when you even think about the cost allocation, their space is designated space.

MR. ARMSTRONG: But it really could be sort of the back end of a nursing unit or -- it's -- I mean, it's really using the other fixed costs of the hospital campus. I mean, I -- a hospital-based IRF I assume looks and feels pretty much like any other nursing unit on a hospital campus. It's not in a separate building and served by support services in a different way?

MR. LISK: No. That would generally be the -- that would generally be the case. I mean, there may be some exceptions, but generally, yes, it would be a unit within the hospital, so it would be like another unit within -- another, you know, wing, you know, portion of a floor of a hospital or something, or a floor of a hospital.

MR. ARMSTRONG: And I know there are all sorts of

standards around rehab physicians and services like that that would be different from that unit. But physically, you know, it's pretty much a part of that campus. Okay. Thanks.

DR. REDBERG: I was also struck by the quality-of-care measures, and I was wondering if we also have some measures that compare the free-standing to the hospitals. Was there a difference in functional improvement there?

MS. SADOWNIK: I don't have that number now. I can look on that measure in particular, the difference in performance between hospital-based and free-standing. Overall, we saw higher quality on average in free-standing facilities, just, you know, on average sort of across -- I should say actually higher quality over time, sort of looking at, you know, over three years who were sort of some of the top performers on quality. But in terms of the raw performance, I can look at that.

DR. REDBERG: And also, when the compliance thresholds changed from 2002 and 2004 and 2007, was there any sense of patients were doing better or worse when more of them were being treated in other facilities and not inpatient rehab or --

MS. SADOWNIK: Are you asking about the, you know, functional improvement in an IRF versus in a SNF or home health?

DR. REDBERG: Yes.

MS. SADOWNIK: You know, there was some -- the CARE demonstration or the demonstration that was using the CARE tool that had been talked a little bit about yesterday that was trying to use a common measurement tool across all those facilities, was starting to look at that. You know, I can provide more detail on it. I think overall there were some areas that IRFs appeared to be doing better and some that quality was fairly consistent across all of them.

DR. REDBERG: I'm just curious because there's a lot of different post-acute care facilities.

MS. SADOWNIK: Right.

DR. REDBERG: And, of course, we want to allocate patients where they're going to do the best, but it's not clear to me because -- and there have been changes naturally over time in that case mix, so I thought it was an interesting temporal trend to be able to look at the quality.

MS. SADOWNIK: Yeah, it's a really important

question, and, you know, I think there's -- you know, the CARE tool is starting to look at that, and it's an important area to look at.

DR. REDBERG: That's great.

My last question. Maybe I'm missing something, but it seems like hospitals would have a lot of control over where they were discharging patients, and I'm surprised that hospital IRF occupancy rates are lower than free-standing because they could preferentially discharge to their own facility. So what am I missing?

MS. SADOWNIK: I think that, you know, maybe you're describing a scenario where there are, you know, both hospital-based and free-standing facilities in the same market, and we didn't look at that in particular. This is sort of national averages.

DR. REDBERG: I see.

MS. SADOWNIK: If that makes sense.

DR. REDBERG: Because I only know the Bay Area market, and I believe that's true in the Bay Area, so I assumed it was true nationally, but --

MS. SADOWNIK: Yeah. You know, there may be markets where they are sort of competing head to head in

markets where there's, you know, a predominance of one versus another.

MR. LISK: One of the large national chains actually kind of looks at what the market is, and there have been cases where they've actually bought out the hospital-based IRFs because there's just too much capacity in that market. So there are some cases where I think the free-standing are going in and being in markets where there isn't as much competition may be one of the factors as to why there's higher occupancy rates in those markets. It's a possibility. There could be other factors, too.

MR. HACKBARTH: So I would like to pick up on Rita's earlier question about the evidence on improvement across different post-acute providers, and there was a passage in the paper about the CARE demonstration. For January, I'd like to learn more about this. If I'm understanding it correctly, using the CARE tool, there wasn't much difference in improvement across the settings. And yet the average payment per case in IRFs, in 2011 it was $17,000. Off the top of my head, I can't quote the comparable numbers from a SNF or home health, but I think they would be substantially lower, and correct me if I'm not

right about that. And if what we're getting is a relatively small gain in improvement, that's something we need to explore further, in particular, when we see the free-standing IRF margins at 20 percent plus. So I'd like to learn more about that between now and January.

DR. MARK MILLER: Could I also -- on the quality point, the two points that I sort of carry around in my head, is on the CARE demonstration, the differences were small or IRFs were maybe a little better. That's kind of what I remember. Then we had some work done by RAND awhile back when all of this was starting to happen, the 60-percent -- or 75-percent rule, which became the 65, which became the 60-percent. And it was very difficult to do the work because there was no common assessment instrument. There was all kind of instrumental variable, you know, so in the end there was some indication that there was higher quality in IRFs, but it was very qualified because of the measurement complications you run into.

The other thing, Craig, I'm trying to remember -- and this is from several years ago, and I could be wrong about this. But wasn't there some work we were looking at, and there was some sense of hospitals selecting who went

into their IRF units, and that there was sort of a conscious or detectable difference in the data of who went where, and we can come back to you. But I think the overarching point is that when the compliance threshold came into effect, the industry, you know, kind of contracted and is sort of figuring out which kinds of patients it's going to focus on, because there were a set of patients that now kind of fell outside of the compliance threshold, and that may be more what is being reflected in the occupancy rates than, you know, a selection process. But that's kind of --

MR. LISK: I think some of that was the case, particularly, let's say, hospitals that had hip and knee departments, they were doing a lot of -- they were taking a lot of those patients into their hospitals. And when the compliance threshold was reinforced, those patients really -- they couldn't take most of those patients anymore, and that really dropped down the occupancy rates substantially in those facilities over time. And then it has gained back up as they have kind of found other patients to replace them.

Some of the free-standing facilities actually had already started not taking those patients as much either as

well, so they didn't have as much of a change to effect when that was -- when the -- the word here -- when the compliance threshold was reinforced. So they didn't have as big a change to make as some of the hospital-based facilities in some cases.

MR. HACKBARTH: So, can I just go back to the improvement issue for a second, because I may be misinterpreting what's in the paper, and if I am, I don't want to leave that just sitting.

So I remember the RAND analysis and their conclusion that was really difficult to make apples-to-apples comparisons. My understanding is that's one of the reasons for developing the care tool, and I thought the research that was being reported in the paper was RTI analysis of a comparison using the care tool, and their conclusion -- well, according to the paper, the risk adjusted analysis found no significant difference in the average degree of improvement of mobility, but a slightly higher gain in self-care outcomes among IRF patients. Where results varied, the difference in improvement among settings was relatively small, less than five points on a 100-point scale.

So the way I'm interpreting that is now we have a tool for making apples-to-apples comparison and what we find is a relatively small gain, less than five points on a 100-point scale, and yet we're paying an average of $17,000 per episode and we've got freestanding facilities that have average margins of over 20 percent.

If there's something in that picture that I'm not understanding, I'm eager to learn more about it. So I'll leave it there.

Alice.

DR. COOMBS: So, one of the things before the compliance thresholds were instituted, a lot of facilities in our area would actually have the IRFs, and in cases where patients were going to have bilateral total knees, they would do a knee, send them to the IRF, and then return them back to the hospital. It made it very convenient for that to happen. So I know that with that threshold compliance, things may have changed as a result of that in that group of patients, particularly.

On Slide 10, one of the questions I had was, looking at the division of nonprofit and for-profit, what percentage of the for-profits are hospital-based, or is it

100 percent freestanding in that category?

MS. SADOWNIK: You're asking what percentage of the nonprofits are --

DR. COOMBS: The for-profit are hospital-based.

MS. SADOWNIK: It is -- let's see. Of the hospital-based, 16 percent are for-profit. You asked of the for-profit, how many are hospital-based. Let me get back to you on that. I'm going just to crunch that in the other way.

DR. COOMBS: Okay, and the same breakdown for the freestanding, if you could break that out, as well. Thanks.

DR. DEAN: Just to comment on your comparing -- and maybe this is round two, I'm not sure -- but I think that's a really tricky comparison because there's different groups of people going into the two types of facilities and the therapy they get is very different, I mean, in terms of on one hand, so presumably the more complicated patients would go to the IRF. On the other hand, they have to be strong enough to take three hours of therapy, which, at least in my experience, is the thing that excludes a fair number of them.

So on one hand, they're healthier, but they also

have to qualify for a much more aggressive form of therapy, so it's really tough, I think, to compare outcomes unless you had a way to, in the beginning, select people that were equivalent, but --

MR. HACKBARTH: The amount that I don't understand about this is just overwhelming, but my premise, and it may be false, is that the purpose of the care tool was to try to make the apples-to-apples comparison.

DR. DEAN: Yeah, and I think that's important --

MR. HACKBARTH: Yeah.

DR. DEAN: -- because, like I say, just to take the two settings and to compare the outcomes probably isn't fair.

MR. HACKBARTH: Well, and the other question I would have is the situation you describe, where the weakest patients don't go to IRFs.

DR. DEAN: Right.

MR. HACKBARTH: The relatively healthy ones go, the people who can benefit from the therapy. Wouldn't that stack things in favor of the IRFs?

DR. DEAN: Well, except that they may have more -- they may be healthier, but they may have more severe

disabilities, if you can --

MR. HACKBARTH: Okay. I see your point. Yeah.

DR. DEAN: So they may have had a really bad stroke, but they're still strong enough that they can take that.

MR. HACKBARTH: Yeah.

DR. DEAN: So it's a very tricky comparison.

MR. HACKBARTH: Okay, and let me emphasize again, I'm just trying to understand, so I'm -- Mike.

DR. CHERNEW: I agree with that whole discussion. I just wanted to say, in that spirit, one way to think about it would be instead of trying to compare IRF versus other setting patients, to look over time at the entire group of patients and as the mix shifts to see if the entire group of patients is seeing a collective drop or not. There's still going to be some issues, because we have this issue of getting the common tool and stuff, but I think we're moving in the right direction.

But I think we could see, as the mix shifts, if we saw a change in quality -- whatever that means -- across the entire group of patients as opposed to trying to compare one group in one setting and one group in another, because

that's really what matters, is what's happening to the entire population of patients as the mix shifts or not from one setting to another.

DR. DEAN: And your question is absolutely appropriate. It's just -- because we do need to find out what's the most efficient way to get people back on their feet, and whether this three hours of therapy is the right approach or not, I think, is still an open question. So, no, I think it's the right question. It's just tough to get an answer.

I guess the clarifying question, on other services, we've seen a lot of geographic variation in terms of availability and cost and all those things. Do you have that information with regard to these facilities?

MS. SADOWNIK: In terms of --

DR. DEAN: Variation from region to region --

MS. SADOWNIK: Yeah, in terms of cost --

DR. DEAN: -- about utilization and cost?

MS. SADOWNIK: I can get you the cost data, and in terms of -- I'm sorry, did you say utilization or availability?

DR. DEAN: Both.

MS. SADOWNIK: Both. I can get all that information for you. We did see lower occupancy rates, but in terms of availability, there is at least one in every State, but certainly a concentration in --

DR. MARK MILLER: Tom, we can do the utilization rates, you know, looking at -- the way we looked at the geographic variation and use and we can come back to you on that.

MR. LISK: You have the map on page four of your mailing material --

MS. SADOWNIK: Right.

MR. LISK: -- that show you the distribution of IRFs across the country.

DR. DEAN: [Off microphone.]

MR. HACKBARTH: Okay. I'm going to stay quiet now because I've been a barrier to progress here, so --

[Laughter.]

MS. UCCELLO: A quick question --

MR. HACKBARTH: Everybody else, be better than I've been. Let me put it that way.

MS. UCCELLO: A quick question on this functional improvement gain. Has there been a change over time at what

the starting point is, because I can see if that changes over time -- you know, how you improve might depend on where you're starting from.

DR. MARK MILLER: And I thought the way I would go at this is -- and just make sure that this is right. So what we did is we constructed quality measures with RAND recently and that's what we're reporting here. Is that correct? Okay. And what we were trying to do, or what RAND was trying to do in that analysis is there was a big shift in this industry because of the compliance. So you had a lot of case mix changing, and in a sense, if this is what your case mix looked like, you were sort of moving this case mix out and remaining this. And then at the same time there was some shift in cases that the industry was kind of responding to.

In the work that we did with RAND, our attempt was to try and control for the change in case mix in measuring this risk that you see here, with all the usual econometric caveats that other people could do better than me. So we're trying to control for the fact that the case mix is shifting during this time period. Is that fair?

MS. SADOWNIK: So last year, we had presented on

changes in quality from 2004 to 2009, where, as Mark was saying, there was dramatic changes in the case mix, so it was important to control for case mix over time. In this year, we only compared 2009 and 2010, and in that case, we did not hold the case mix steady in the same way that we did for last year's analysis, for the retrospective over time, but the case mix shift was very small, which was why we didn't. So, you know, certainly because it came more into play there.

MR. KUHN: I'm interested in the compliance threshold and access. So in the paper, it talks about an RTI report that CMS -- or CMS contracted with RTI to do a report that came out in 2010, and apparently, in that report, if I understand it right, really couldn't determine whether the compliance threshold was causing issues with beneficiary access to intensive rehabilitation services.

At the same time, on Slide 6 that we have here, we show occupancy rates that would be indicative that there is not an access issue.

So I'm just curious, what was the criteria that RTI used where they were unable to definitively make a determination? I mean, did they look at -- I mean, if they

look at these occupancy rates, I think that would lead them to one conclusion, but I'm curious whether other things that they were looking at access that we ought to be aware of as part of our deliberation here.

MS. SADOWNIK: Yeah, I can't speak to that. I'd have to go back to the report and check.

MR. BUTLER: First, just as a follow up to Scott's question, we're an example where rehab units are in a separate but physically attached to the main campus buildings. I'd characterize the rehab units in hospital-based are a different infrastructure than, say, like swing beds or a SNF. I mean, you have to have the physical and occupational therapy to meet CARF accreditations. It's a pretty big investment. So it's a little different than just flipping a patient unit, for sure.

So I have three questions. None of them are real easy. In the chapter itself, in Table 12, these occupancy rates look pretty stable across the for-profit and the -- I mean, the freestanding versus the hospital-based, and I suspect that that would -- if you went back to 2004, as the Table 12 does, probably, you'd find similar stability. But the profitability in the hospital-based in that time period

going from 2004 to 2011 has gone from 12 percent margin for the hospital-based down to a negative 0.8, where the freestanding has kind of stayed about around the 20 during this time.

So I struggle with what has happened during that time, because I don't think the units -- I think that the economy of scale issue has existed for that entire period of time, so what is it about the management of these things over that period of time that has changed? This is what still leads me to think that the patient mix issue is a little bit different than what's going on in the two settings. Do you have any thoughts about what would decline? It's not on there, but in the chapter, you've gone from 12 percent margin to zero in hospital-based, again, and stayed the same in the freestanding.

MS. SADOWNIK: I don't have a particular insight on that. I think the point that Craig had made earlier about the emphasis on orthopedics, how that may have -- it may have been, you know, more a piece of the hospital-based line of business in terms -- you know, that may have been more integral to their line of business or --

DR. MARK MILLER: I think it's --

MS. SADOWNIK: -- sort of having integrated care, but besides some of the importance of that, I don't --

DR. MARK MILLER: Yeah, I think it's the point that we were talking about. I think, in some cases, these units were more heavily invested in what the compliance rule started to say needed to come out of these facilities. Craig, that's kind of --

MR. LISK: I mean, I think that's part of it. I think the other thing is that in terms of the focus, if you think of managerial focus in terms of efficiency and stuff, is when you have this as just part of your facility in terms of the emphasis for the management for controlling the cost growth, I think there may be some differences there, whereas where you have the freestanding, their whole business is on the IRF side, and so they may have more emphasis of controlling what has happened with the cost growth there, too, may be another factor contributing to the difference in the margins, as well.

MR. BUTLER: Yeah. You will also notice in Chapter 2, though, that -- and I realize the risk adjusted severity by tiers looks like it's the same across the hospital-based and the freestanding, yet the mix by

diagnosis has changed so that the hospital-baseds are treating a lower percentage of orthopedics than the freestanding now and a greater percentage of the strokes. It just makes me wary a little bit. So --

MR. LISK: Just to say, the other thing that could be happening is because the person is in that hospital, it may be easier to transfer that patient a little bit earlier than when it goes to freestanding, so there could be something there, but we'd have to do more investigating on that.

MR. BUTLER: So I've got some biases for round two, and this is a real dilemma because these are such high margins, you know. What do you do with the hospital-based?

So, in general, Medicare as a percentage -- in some of these sectors, Medicare is almost the only payer. Here, I don't know what it is, whether it's -- you know, for ourselves, it might be, like, 60 percent of the business is Medicare, somewhere in that range, and I would expect that -- would that be typical in the sector, in general?

MS. SADOWNIK: [Off microphone.] Yes.

MR. BUTLER: Okay. Then we don't probably know a lot about the payer mix of the other 40 percent, and in the

freestanding, I suspect you would see some patterns like you do in ambulatory surgery, maybe not as dramatic, but I'm willing to guess that there's a lot less Medicaid and virtually no or very little free care, for example, in the freestandings, but I don't know. That sounds like a comment rather than a question. It's a speculation.

DR. MARK MILLER: [Off microphone.] Is it something we can know?

MR. LISK: We can look at the Medicaid side of things, yeah.

MR. BUTLER: I mean, I just find in our own unit, we're getting swamped where there's no other -- there are no rehab units that will take -- I mean, we take them because we have them, and I suspect that a lot of people wouldn't take some of the non-Medicare lousy payers. And there's nowhere else to go. Okay.

MS. SADOWNIK: We can look and we can get back to you on the payer mix, or on the Medicaid.

MR. BUTLER: Part of this has to do -- the longer-term impact of if this follows the route that SNFs do over time, where hospitals kind of get out of it, and yet we're left with mostly freestanding for-profits that are not

participating in their equal share of treating all patients. We have a different kind of supply issue in the long-term that we ought to be cognizant of.

DR. BAICKER: So two quick requests for more information that are probably not on hand right now. One was following up on Rita's questions. I was interested in the difference in quality between the freestanding and hospital-based, particularly because my reading of -- my more naive reading of the table of conditions was that they were pretty balanced. They looked fairly similar in terms of the types of cases they were treating, and it sounded like the case mix within those cases, you have the patient severity was fairly similar across the two, so it would be very interesting, then, to see how the quality compared across the two, given the striking difference in the margins.

That also made me think about the sorting of patients across these different types of facilities, as we've talked about, across silos, and you had interesting statistics about the share of each type of patient within IRFs. You know, 20 percent of the IRF patients were for this condition and ten percent for that condition. I'd be

interested to know what share of the patients with that condition were treated in IRFs. In other words, how much substitutability is there across sites based on the patient's underlying condition and is it really -- Tom highlighted the sort of funny characteristics of a patient that makes that patient suitable for IRF. They have to have a severe condition but be relatively healthy within that severe condition. It's a funny kind of selection, and I wondered how much possibility there was for sorting across sites based on where those conditions are treated.

DR. NERENZ: This may be an extension of Peter's question, but on Slide 11, when you talk about the cost per case difference, it's very striking. What do you know, or what can you tell us about some of the underlying components or drivers of those differences, either the direct or the indirect?

MS. SADOWNIK: Besides the economies of scale factors?

DR. NERENZ: Well, that's clearly one.

MS. SADOWNIK: Yeah.

DR. NERENZ: It may also be that there's some cost allocation issues going on in the hospital-based that play

into this in some way, economies of scale. But I guess I'd still want to know, what does economy of scale mean exactly in this particular setting, or is it just driven by the occupancy rate? I'm just curious, how should we interpret that difference?

MR. LISK: There is, in terms of for the IRF industry, when you think about -- the economies of scale probably is actually a big factor here in terms of -- even incrementally in terms of how you design a unit, and so from what I've heard from some research, one of the firms said basically that you have to have lots of 22 beds, is basically what is an efficient way. So 22, then 44. So, basically, 20, 40, 60. And a lot of the hospitals, you know, if you're at 15, you're not going to be that efficient, so you're going to have both higher direct costs and higher indirect costs because of that.

The indirect cost share, in terms of the overhead cost share, actually is lower in hospitals than compared to the freestanding hospital. So in terms of that extra cost allocation, which we may actually see on the home health side, where we see higher indirect costs on home health hospitals, we don't see that in the IRF side. Now, the

actual indirect cost per case is actually higher, but it is likely a function of the size of the unit and the economies of scale.

If you look at the hospital-based that are 60-bed units, they actually have pretty good margins. They're not as high as the freestanding. But, again, I think there's some of that just -- some of that higher margin in the freestanding may be because of their focused facilities, so they're able to be just more efficient and you have a chain that is focused with half of those freestanding -- one chain has half of those freestanding. And so they are probably just also corporately efficient, as well, which may be a reason for those high margins and the greater efficiency there. It's another speculation there, but that's how I interpret some of the data there.

DR. SAMITT: So two quick information requests. One should be easier than the other.

Similar to Alice's question on Slide 10, I'd be interested in a four-quadrant analysis looking at the for-profits that are freestanding versus hospital and the not-for-profits that are freestanding versus hospital. Mostly, I'm interested in understanding, are there freestanding

institutions that have profit margins up in the 20 percent range that are not-for-profit? So is there anything to learn in that space? I think it would be interesting to have that analysis.

The second, which is probably harder, is I'm wondering if there's any data to indicate what we would expect -- would we expect to see a change in utilization of IRFs as a result of readmission penalties to hospitals and whether we're beginning to see that. What you could imagine is that we may see a tendency to shift to greater utilization of IRFs for fear of readmissions versus SNFs or home care, and it may be too soon to really get some kind of indication, but I'd be interested in seeing if anything is available.

MR. LISK: That's an interesting question, because I kind of wonder about the increase in the IRF use just recently, from 2010 to 2011, where you're seeing more focus on hospitals in 2011 dealing with the readmission policy. I don't know whether that might be, but that's an interesting --

MR. GEORGE MILLER: Yes. If I recall, I'm not sure, but I'm not sure the readmission penalties are on the

three modalities that would lend to an IRF. I don't think so, but it would be good to find out. Yeah.

MR. HACKBARTH: The readmission penalties are on cardiac --

MR. GEORGE MILLER: Cardiac, right --

MR. HACKBARTH: -- and CHF --

MR. GEORGE MILLER: -- congestive heart failure. Those normally wouldn't go to an IRF, yeah.

MR. HACKBARTH: Yeah.

MR. GEORGE MILLER: I don't think so, but --

MR. LISK: I mean, there's some of those --

MR. GEORGE MILLER: -- still a good question.

MR. LISK: Some of those patients might, but --

MR. GEORGE MILLER: Right. Right.

MR. LISK: -- but there's some overall, hospital behavior overall --

MR. GEORGE MILLER: Yeah.

MR. LISK: -- that may extend beyond those conditions to --

MR. GEORGE MILLER: It's still a good question to ask in the race, but a couple things I'd like to focus on.

One, demographically, I was somewhat surprised

that the Hispanic population was so low in the reading material, four percent versus eight and growing in the population. Is there a reason for that? Have you been able to tease out why that is the case? It was in the reading materials.

MS. SADOWNIK: Right, why the Hispanic population was lower --

MR. GEORGE MILLER: Yes.

MS. SADOWNIK: -- at IRFs than in the general population?

MR. GEORGE MILLER: Yeah. Yeah. The others seemed to be mirroring the general population.

MS. SADOWNIK: Yeah. I don't have any insight into that right now. I can -- we can think about that. It's not -- I believe it's not unique to IRFs compared with -- I believe SNFs actually have a similar trend, so --

MR. GEORGE MILLER: Yeah. Interesting. But the other question has to be -- excuse me, is, for me -- has to be interesting on the map you put in the reading material, which I thought was fantastic. But I was surprised with the circles of ten or more IRFs and their distribution across the United States. At least in my mind, it is surprising

where they were, and particularly the dots in -- I was surprised how many are in Louisiana, as an example. It's an interesting place to have a lot of IRFs.

I guess my question is, is the industry ripe for consolidation? Would it mean that we may see consolidation there in the future? It would seem to me that that would make some sense, especially with some of the largest chains. But the map doesn't seem to indicate that, so I'm not sure what to draw there, but it's just interesting. I don't know if you've done any work or research of why they are where they are located, what drives the number of IRFs in some interesting places and not in some other places, where you see large populations, large rural areas, but you don't have that type of consolidation. So what is it about IRFs in some of these places, if you've been able to figure anything out? What drives that? Again, particularly, I'm surprised at some of the dots in Southern communities that have ten or more. Any feel for that? Any understanding for that?

DR. MARK MILLER: I mean, that is also something that we can come back to you on. I'd be surprised if we knew off the top of our head. Remember, though, with Louisiana, we find this pattern repeatedly, LTCHs --

MR. GEORGE MILLER: I know.

DR. MARK MILLER: And so there is definitely something going on down --

MR. GEORGE MILLER: But isn't that kind of a signal --

DR. MARK MILLER: An issue? Yes.

MR. GEORGE MILLER: An issue, yeah. A red flag.

DR. MARK MILLER: And I think you may have raised that red flag yesterday, and I think you were right then when you raised it as well. And so we can kind of put the same microscope that you raise yesterday on this and see if we can come up with anything here.

MR. GEORGE MILLER: Yeah. And then, finally, like Peter and Craig, I'd like to see the margins free-standing -- excuse me -- the margins for hospital-based as it relates to those that are free-standing and then those -- excuse me -- hospital-based that are managed by a for-profit entity versus those operated by the hospital and see if there's a difference in margins there.

Thank you.

DR. HALL: Could we look at page 8 again, the quality-of-care slide? I just wanted to check out some math

here for a minute. Toward the end of that, the last two columns, the discharge to acute-care hospital and then hospital readmission after 30 days, those are not -- they're separate numbers. Does that really mean that within 30 days, 22 percent of people admitted to an IRF will return to a hospital? So we have 10.3 percent that go back to the hospital, and then those sent to the community, within 30 days 12 percent. So almost one-quarter of all patients that go to an IRF end up back to a hospital. That surprised me. That's a really very high number.

And sort of the flip side of what Craig was talking about, if there is any strategy of acute hospitals to use IRFs as kind of an escape valve for discharging patients to reduce length of stay in the acute-care hospital, this is kind of a fool's game because --

MR. GEORGE MILLER: Yeah.

DR. HALL: -- a lot of them are going to come back. And I notice only 5 percent are cardiac diagnoses, so right now the readmission penalty wouldn't hit them, but it probably will eventually.

Is there any kind of benchmark here that says what should that number be like? Is there enough, a small cadre

of these institutions or of IRFs that don't have these kinds of return numbers? You know, whether they're the most efficient or whatever.

MS. SADOWNIK: Yeah, we can look at the distribution of performance.

MR. HACKBARTH: You used the expression, Bill, "it's a fool's game." It's a fool's game from a Medicare perspective.

DR. HALL: You bet.

MR. HACKBARTH: But from the perspective of the hospital --

DR. HALL: Right.

MR. HACKBARTH: You get a readmission, and you get the additional revenue associated with that. You shorten the length of stay on your initial readmission; you benefit from that. And so, you know, under the existing payment rules, this looks like a win-win from a provider perspective.

DR. HALL: Right. And Alice's comment about if you're going to do double knees, just send them to the IRF and then come back. It's a good thing we don't have four legs instead of two, right?

[Laughter.]

MR. HACKBARTH: Right.

DR. COOMBS: What I was going to say is that discharge to acute-care hospitals is not always a bad thing. It might be that someone says I want you to go here, get yourself together, and get you all spruced up, and then come back for whatever procedure you need.

MR. LISK: That is the sometimes the case. And then when you're talking about the cardiac stuff, there are some IRFs that -- even though doing it within the compliance threshold, there are some IRFs that kind of specialize in some cardiac rehab type of stuff, so they have a higher share, so there's some kind of unevenness in that, but they're doing it within the compliance threshold type of thing, too.

DR. NAYLOR: So I really like the way that this chapter has uncovered many, many opportunities to take a look at what's happening here and relative to what's happening in alternative SNFs and home health. So I'm wondering, in addition to the great ideas in terms of data, especially since there has been such a dramatic change in case mix to patients more with brain injuries and stroke and

so on from when this started and with the threshold rule, if we could do a little bit longer look at this rather than a point in time one year, changes in FIMs, et cetera, we could have a little bit of a trend data that could help us look both within and across settings, as Mike has suggested, but also is there a way to relate this -- and hospital-based versus free-standing. But is there a way to relate this to -- you described decreasing compliance with a 60-percent threshold. Is that right?

MS. SADOWNIK: A decrease in compliance with a 60-percent threshold?

DR. NAYLOR: So maybe I misunderstood. It said, "The rate of compliance with respect to the 60-percent threshold has been decreasing."

MS. SADOWNIK: Oh. Sure.

DR. NAYLOR: And I just wanted to know whether or not any of these outcomes might be connected with rate of compliance with the threshold.

MS. SADOWNIK: Yeah.

DR. NAYLOR: [off microphone].

MS. SADOWNIK: Right. It's -- you know, I think in recent years, it's been -- you know, it has been a

decrease but very slightly, of course. So --

DR. NAYLOR: So it's not a big -- I'm sorry. It's not a big issue then.

MS. SADOWNIK: I think -- right. You know, and certainly once -- you know, looking from 2010 to 2011, from 61.6 to 61.2. So I think, you know, there's much more instability when the -- you know, in earlier years when the -- you know, when regulations were changing and enforcement was changing. But, you know, in a more recent time window, the differences have been pretty small.

DR. NAYLOR: So I think the trend a couple years in looking at this would be great rather than a snapshot, single snapshot. Thanks.

DR. REDBERG: Can I --

DR. HOADLEY: Yeah, my questions have mostly been hit on the geographic sort of distribution questions. Looking at the map, sort of going the opposite direction that George was talking about, you know, it's pretty well covered, it looks like, in your comment that they're in every state, but I'm wondering are there some markets that really have none or very little presence of these facilities. But then maybe more importantly, and it goes

to, again, a question that has come up, the differential distribution of the hospital-based and the free-standing, you know, would the map look very different if we looked at the hospital-based only and the free-standing only, including the question that a couple people have already raised of how often are there markets that are all one or all the other. I think just understanding a lot of that dynamic would be really helpful.

MR. HACKBARTH: Okay. We are now 10 minutes over what we had allocated for this whole session, so on Round 2 I'd ask people to keep that in mind. I don't want to discourage important comments, but if we could move as quickly as possible, that would be good.

As usual, in Round 2 I'd like you to give us an indication of where you stand on the draft recommendation, whether you support it, if not, what you would like to see changed.

MR. ARMSTRONG: In general, the issue I have is that we're paying a real premium for IRF services, and it's not clear we're getting our money's worth relative to the other alternative post-acute services. But that's not an issue we can resolve through this decision. Given the

margins and other points we've made, I support the direction that you're going in. It may be a little generous.

DR. REDBERG: I agree. Obviously, I think we're all concerned that $17,000 -- I mean, if it was going for sicker patients and better improvements -- so I do have concerns, and I'm sure we'll see more about it.

I support the Chairman's draft recommendation for this, although I could go lower.

MR. HACKBARTH: I would like the record to show the use of "generous" when applied to me. It's not one that I'm used to hearing.

[Laughter.]

MR. HACKBARTH: Perhaps we could put that in bold in the transcript.

[Laughter.]

DR. COOMBS: I think there's so many questions that have come up, I have in the back of my mind the possibility that there might be margins in great excess when you break down the specific groups, and I'm just curious as to that result.

With all this being said, I support the recommendations of the Chair.

DR. DEAN: Yeah, I support the recommendation. I just was looking. This probably should have been in Round 1, but on Table 12 in the mailing material, it's really striking that the margins for free-standing have been relatively stable for a long time, and there has been a -- go back to '04. The hospital-based had a margin of 12 percent, and it has steadily decreased until it was negative in '11. Do we have any idea what was the reason for that trend? It's a striking trend compared to whereas the free-standing were pretty stable.

DR. MARK MILLER: This is the question that came up, I think, over here, and we'll put some thought into that.

DR. DEAN: Okay. Anyway, generally I support it.

MS. UCCELLO: Yeah, I agree, and like some of the others, depending on what comes out, could be convinced to go lower.

MR. KUHN: I support the recommendation.

DR. CHERNEW: I support the recommendation.

MR. BUTLER: I support, but just a short editorial. In the absence of -- this is Exhibit A and LTCHs will be Exhibit B of why we need to look at the post-acute

options as a collective set of tools. And the one thing I would highlight is that I've brought up before that every hospital now has their medical spending per beneficiary data in hand. This includes the three days prior and 30 days post-acute stay data that is scheduled to be part of value-based purchasing in 2015. If you look at this data, it shows that approximately 30 percent of the episode spending in the aggregate is in the post-acute. And to the extent that hospitals now will be subjective in a value-based purchasing for those options, it will begin to look -- in addition to ACOs and Medicare Advantage plans, it will become much more obvious, the cost of these alternatives and whether or not they are better than, for example, home care, which tends to be the least expensive, but that doesn't mean it ought to be the only option in post-acute care either.

DR. BAICKER: I support the recommendation and second the strong sentiment that we need to harmonize across these post-acute care settings.

DR. NERENZ: I generally support. I just still am struck by this difference in the cost structure between the two types of settings, and I could imagine us being at least receptive to an argument from the hospital-based side that

these facilities were providing some sort of essential access function, perhaps being the only source in certain areas, and that the cost structure was simply inevitable and a result of things that could be defended. I have not hear such an argument, and you have not given us such an argument to consider. So in the absence of such an argument, I'm in support.

DR. SAMITT: I support the recommendation, and I thought also about the notion of whether we should go lower, although I'm a bit concerned about hospital IRF margins, especially in the setting where there isn't a readily available large nonprofit. And so I think we just have to be cautious.

This is another example of kind of the danger of viewing payment to IRFs as a silo from the rest of the system, especially as it pertains to expanding diagnoses for hospital readmission penalties, we may see the utilization of IRFs inappropriately increase if the referring hospitals were accountable for the cost implications and quality outcomes of where they refer post-acutely to, then I think that we would address those concerns. So it goes back to, again, the notion of needing to bundle and not just view

other post-acute options separate from each other, but also look further upstream to the physicians and the hospitals that are referring them to those institutions.

MR. GEORGE MILLER: Yes, I'm going to be consistent with my statements from yesterday. I'm a little bit concerned that the Hispanic population is not equally represented. In general, I would support the recommendations, or lower, but I do have, like both Peter and David expressed a concern, the difference between hospital-based versus for-profit where in the areas of the country that is the only source for these patients. Otherwise, I would feel strongly that we should probably lower your recommendation -- or the recommendation, lower it, because I must stay consistent that the Medicare program should be available to everybody, and if it's markedly different for all beneficiaries, no matter where they are demographically, I have a problem.

DR. HALL: I'm also in support of the recommendations. I'm a firm believer in the advisability, even necessity of some form of rehabilitative and restorative services for Medicare patients after hospitalization. I don't think this is going to be the

long-term answer, though, this high-margin service that serves a relatively small proportion of Medicare patients by virtue of the constrictions put on admissions.

So I think we've got a lot of work to do, but I think we should approve this as it is for now.

DR. NAYLOR: I also support the recommendations and echo comments of colleagues about the real opportunity here to urgently develop a rational post-acute system that aligns with people's needs and gets us to more efficient and effective care for them and for the program.

DR. HOADLEY: I also support the recommendation and, like others, echo what Mary just said and others have said, but also the notion that depending on what we learn about some of these side questions, could even be a lower update than in the recommendation.

MR. HACKBARTH: Okay. I think this has been a good discussion, and we've identified some important issues, a few of which we may be able to answer the questions before January, others that won't be possible. And, you know, that influences my thinking about how quickly to move here. It may be that over time a reduction in the rates is appropriate, but I think we need to move with some care in

that regard.

Just one other thought. At the end of our session yesterday I said from my perspective one of the advantages of moving towards bigger bundles is that it facilitates the flow of resources to where they can be most effectively deployed. Then I combine that thought with looking at individual silos and trying to push down the rates and eliminate -- reduce the resources available. Those two things may be at odds. You know, maybe what we want to do is have the resources, just have them deployed elsewhere in the system in a way that they would more effectively contribute to better care for patients. If we sort of squeeze them out silo by silo, then they're gone, and there isn't that opportunity to redeploy in more effective ways.

So for me, that's just one more argument in favor of moving quickly towards new payment models and getting out of this silo-based approach.

Thank you, Sara and Craig.

Now we move on to long-term care hospitals.

MS. KELLEY: Good morning.

Some patients with medically complex problems need hospital-level care for extended periods of time. In the

literature, these patients are described as the chronically, critically ill, or CCI. Nationwide, most CCI patients are treated in acute care hospitals, but a growing number are treated in long-term care hospitals.

As you know, the Commission has called for the development of criteria to define the CCI patients that are treated in LTCHs and other similar settings, such as acute care hospital step-down units and specialized SNFs. In the coming months, I hope to bring you some more information and analyses on criteria for LTCHs, but today I'll be focusing on the analysis of payment adequacy for this setting.

First, just a little bit of background information. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average Medicare length of stay of greater than 25 days. Due to these long stays and the level of care provided, care in LTCHs is expensive, averaging more than $38,000 per case in 2011. Medicare pays LTCHs on a per-discharge PPS, and it uses the same MS-DRGs as the acute care hospital PPS but with different weights. Payments can be adjusted upwards for cases with extraordinarily high costs and downwards for short-stay

outliers.

Following implementation of the PPS in fiscal year 2003, Medicare spending for LTCH services grew rapidly, as you can see here, climbing an average of 29 percent per year between 2003 and 2005. This growth prompted concerns about the demand for LTCH care, patient selection and the possible unbundling of services covered by the acute care PPS. And, as a result, CMS implemented a number of regulations addressing those concerns.

Following that, between 2005 and 2008, growth in spending slowed to less than 1 percent per year.

After Congress rolled back, or delayed, implementation of some of these regulations, spending for LTCH services began to climb again, rising 12 percent between 2008 and 2010.

Spending growth slowed somewhat between 2010 and 2011 due mostly to a reduction in the payment rate. Spending totaled $5.4 billion in 2011.

Our first consideration in our analysis of payment adequacy is access to care. We have no direct indicators of beneficiaries' access to LTCH services. So we focused on capacity and use, but it's important to keep in mind that

this product is not well defined and it's often not clear what Medicare is purchasing with its higher LTCH payments.

There are no established criteria, as I said, admission to an LTCH. So it's not clear whether, or which, patients treated there require this level of care.

And, remember that many Medicare beneficiaries live in areas where there are no LTCHs and so receive similar services in other facilities.

Research has shown that outcomes for most medically complex beneficiaries who receive care in LTCHs are no better than for those for similar patients who don't have an LTCH stay.

To gauge access to services, we first looked at capacity. This slide shows growth in the number of LTCHs nationwide, in green -- it might be a little hard to see. Sorry about that -- and the number of beds in blue.

From the late 90s until 2005, the number of LTCHs more than doubled, and you can see the tail end of that growth here.

Beginning in 2005, as CMS implemented those payment regulations that I mentioned, facility growth slowed markedly. Although Congress temporarily eased some of those

regulations, facility growth has remained low due to a moratorium on new facilities that's been in place for the last five year. That moratorium is due to expire at the end of this year, 2012.

In spite of the moratorium, we continue to see growth in the number of LTCH cases per fee-for-service beneficiary. That number rose 2.8 percent between 2010 and 2011, suggesting that access to care increased during the period.

Turning now to quality, LTCHs just began submitting quality data to CMS this past October. CMS is required to implement an LTCH pay-for-reporting program beginning in fiscal year 2014.

To start, LTCH quality will be measured on three dimensions that I've listed here: catheter-associated UTIs, bloodstream infections due to central lines and new, or worsened, pressure ulcers. Until these data are available for analysis, we continue to rely on claims data to examine trends in in-facility mortality, mortality within 30 days of discharge and readmission to acute care to assess gross changes in quality

In 2011, these rates were stable or declining for most of

the common LTCH diagnoses.

Access to capital is the next step in our payment adequacy analysis, and access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of Medicare payments since Medicare accounts for about half of LTCH total revenues in aggregate. However, for the past few years, the availability of capital says more about uncertainty regarding changes to regulations and legislation governing LTCHs than it does about current reimbursement rates.

Since 2007, the moratorium on new beds and facilities imposed by MMSEA has reduced opportunities for expansion and the need for capital. With the moratorium expiring, it seems reasonable to expect that LTCHs are poised to expand existing capacity or open new facilities, but market analysts that we spoke to are doubtful that this is the case, at least in the near term. CMS's continued scrutiny of Medicare spending on LTCH care and uncertainty about possible congressional action may be prompting some caution.

As an example, analysts pointed out that the

moratorium does not prevent LTCH companies from expanding their operations through mergers with, or acquisitions of, other existing LTCH, but no such transactions have happened in the last year. One major LTCH chain which controls about a quarter of all LTCHs has continued to acquire other post-acute care providers, which suggests it is able to access needed capital. But smaller chains and non-profits might not have the same level of access.

So how have LTCHs' per-case payments compared to per-case costs. In the first years of the PPS, LTCHs appeared to be very responsive to changes in payment, adjusting their costs per case as payments per case changed. Payment per case increased rapidly after the PPS was implemented, climbing an average 17 percent per year from 2003 to 2005. Cost per case also increased rapidly during this period albeit at a somewhat slower pace.

Between 2005 and 2008, as changes were made to LTCH payment policies, growth in payments per case was outpaced by growth in costs. During that period, growth in payments per case slowed to an average of 1.5 percent per year.

After the Congress delayed the implementation of

some of CMS's regulations and CMS implemented a revised classification system, growth in payments per case began to pick up again.

Between 2008 and 2009, growth in payments per case was 5 percent, more than twice as much as the growth in costs.

Payment growth slowed after that to an average of 1.6 percent per year between 2009 and 2011. Cost growth has been held under 1 percent per year during that period.

Margins have, of course, tracked the trends you see here, rising rapidly after the implementation of the PPS from a bit below zero to a peak of 12 percent in 2005. At that point, margins began to fall until 2008 when they began to increase again.

And this next slide shows 2011 margins for all LTCHs combined and for different LTCH groups as well as the share that each represents of total providers and total cases. As you can see in the top row, the aggregate Medicare margin for 2011 was 6.9 percent. There is wide spread in the margins, similar to what you've seen in other settings, with the bottom quarter of LTCHs have an average margin of minus 9.2 percent and the top quarter having an

average margin of 20.6 percent. However, our analysis found that margins increased between 2010 and 2011 for all categories of LTCHs.

There is a substantial ownership effect, as you can see. Three-quarters of LTCHs are for-profit, and they posted an average margin of 8.5 percent in 2011. The margin for non-profits, as you can see, is much lower. One reason for this difference may be that non-profits tend to be smaller than for-profits and so they may have fewer economies of scale.

We looked more closely at the characteristics of established LTCHs with the highest and lowest margins. This slide compares LTCHs in the top quartile for 2011 margins with those in the bottom quartile. As you can see in the top line, low-margin LTCHs had standardized costs per discharge that were 36 percent higher than high-margin LTCHs, and this appears to be the primary driver of differences in financial performance between these two groups.

High-margin LTCHs tend to be larger, as I said, and to have higher occupancy rates, so they may benefit more from economies of scale. And high-margin LTCHs have far

fewer high-cost outlier cases and lower outlier payments, and they have a lower share of short-stay cases. Finally, high-margin LTCHs are much more likely to be for-profit.

To estimate 2013 margins, we modeled the impact of several policy changes. We included the payment updates for 2012 and 2013, and for both years this update was adjusted by a PPACA-mandated reduction. We also included regulatory changes in 2013 that we expect will reduce payments.

First, CMS is taking a budget neutrality adjustment over three years beginning in 2013. This adjustment is intended to correct for CMS's underestimate of how much LTCH spending would increase in the first year of the PPS.

CMS has also made changes to the short-stay outlier policy that we also expect will reduce payments.

All together, we estimate that these effects will result in somewhat greater growth in provider costs than in provider payments, and we've project a margin of 5.9 percent in 2013.

So, to sum up our update analysis, the moratorium has stabilized the supply of facilities and beds, but we continue to see growth in the volume of services.

We have little information about quality in LTCHs, but mortality and readmission rates appear to be stable.

The moratorium has limited opportunities for expansion. So access to capital is difficult for us to assess and may not be a particularly meaningful measure at this time.

Our projected margin for 2013 is 5.9 percent, and our projected decrease in the aggregate margin is consistent with expected effects of congressional-mandated and regulatory reductions in payment updates.

We make our recommendation to the Secretary because there's no legislated update to the LTCH PPS. The Chairman's draft recommendation is that the Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2014.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2013 will produce savings relative to the expected regulatory update even assuming PPACA-mandated reductions. We don't anticipate any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

So, with that, I will conclude and turn it over to you for discussion. I'm happy to answer any questions.

MR. HACKBARTH: Okay. Thank you, Dana.

Would you put up slide 9, please?

So would you remind us what payment system was in effect prior to 2003?

MS. KELLEY: Sure. Before 2003, LTCHs were paid under the TEFRA rules, which essentially was a cost-based payment system with limits on reimbursement. Facility-specific limits, rather.

MR. HACKBARTH: So, for anybody who believes that moving to prospective payment is, by definition, a step in the right direction to move toward efficiency, it seems to me this graph should at least raise some questions in their mind.

Every year, you know, we look at this. In fact, if you do a similar graph for home health, as I recall, you see a very similar picture -- move to prospective payment; both payments and costs have increased.

So a payment method alone is not necessarily going to lead to lower costs.

That's for the new commissioners. This graph is

one that Nancy Kane, a former commissioner, used to comment every year, as sort of a sobering reminder.

Jack, do you want to lead off with clarifying questions?

DR. HOADLEY: Sure. I guess I'll go to geography again.

And, obviously, this is a sector where the geographic distribution, as you pointed out, is not uniform around the country. There's obviously not been a lot of growth, but has the growth modified that as the -- to the extent that there have been new facilities, have they gone into areas that already have facilities, or have they gone into areas without?

MS. KELLEY: Almost without exception, they go into areas where there are already are LTCHs, yes.

DR. HOADLEY: Okay. And, you know, you talked about the fact that where there aren't facilities people do find -- and I know from my own work, you know, people find their way into SNFs and other sorts of things. I mean in some ways it's an interesting, you know, case study of substitutability.

I guess I also was wondering about how often there

are multiple facilities competing in a market and whether there's any relationship there to the margins that we see.

MS. KELLEY: Very often, there are LTCHs competing within a market.

I have not looked at margins on that metric. That could be interesting to do. I will see if I can do something like that.

DR. HOADLEY: Okay. Good. Thank you.

DR. NAYLOR: Thank you for a great report.

In the top MS-DRGs that are now the focus, there's been a pretty substantial change in them in recent years, meaning a 49 percent change in the number that are now coming into these LTCHs with respiratory failure and a pretty substantial reduction in others.

And I'm wondering if you could comment on the changing face of the people served in LTCHs. Or, does this have to do with the MS-DRG system's changes?

MS. KELLEY: I don't think it's due to the MS-DRG changes. The literature would suggest that we -- our technology has gotten to a point where we are saving many more people than we used to save in the past and that coming out of hospitals there are many more patients who are

ventilator-dependent or who have other respiratory issues that require a high level of care. And, certainly, the discharges from acute care hospitals of patients who require prolonged mechanical ventilation has increased markedly. And I think that's some of what you're seeing reflected here.

I also think that over time the -- I think several years ago there used to be more overlap in the patients that were in -- nationwide, in the patients that were in SNFs and those that were in LTCHs.

But I think, as we have pointed out for many years, payment for certain medically complex patients in SNFs was probably not what it should be, or relative to payment for other types of patients but did not produce the same kinds of margins, and many SNFs became less and less interested in taking these patients. They can back up in acute care hospitals, and I think in some areas LTCHs have stepped in to sort of take those patients in.

DR. HALL: Along the same lines, table 3, which has the top 25 diagnoses -- you know, the respiratory diagnoses just dominate this list all the way through. It's probably 75 percent of what goes on here. Do we know

anything about how that relates to the difference between high and low-margin facilities?

Is that a --

MS. KELLEY: There is -- you know, the respiratory diagnoses are so prominent here that basically all facilities - all LTCHs take care of -- a large share of their patients fall into these respiratory diagnoses.

Generally, the facilities with higher case mix do have higher margins. That's a broad statement but generally true.

And so -- and some of the respiratory diagnoses are among the higher weighted DRGs.

DR. HALL: Thank you. I'll come to that.

MR. GEORGE MILLER: Same as Jack mentioned on the geographic distribution -- and I'll make my same comment about Louisiana again.

My question, more specifically concerning the outcomes -- do we have an understanding if patients with the same diagnoses, as was just mentioned about respiratory, have different outcomes going to the LTCH versus going to other places, particularly in those areas where there are few, or no, LTCHs?

And then, my second question deals with the growth area where all the growth is specifically where other LTCHs are. Should we consider maybe recommending a moratorium?

In my mind, that makes no sense; that's where the growth is -- where there are already LTCHs.

MS. KELLEY: Extending the moratorium, you mean?

MR. GEORGE MILLER: Yes.

MS. KELLEY: Yes. I think that the --

MR. GEORGE MILLER: I mean, there must be an exception. They can grow now. I'm saying, how do we --

MS. KELLEY: Well, there were exceptions to the moratorium that allowed facilities that were already in the pipeline to continue.

MR. GEORGE MILLER: Okay. Oh, I see.

MS. KELLEY: And then, the pipeline was sort of broadly defined to include anyone who already had a certificate of need.

MR. GEORGE MILLER: I got it. I got it.

MS. KELLEY: Which could be several years old.

MR. GEORGE MILLER: Sure, sure. I got it.

MS. KELLEY: So that's why we continued to see a little bit of growth throughout the moratorium, especially

in the early years.

MR. GEORGE MILLER: I got it. Okay.

MS. KELLEY: But that does seem to have, you know, leveled off as the moratorium went on.

Yeah, I think that the real issue there is the certificate of need. In states that have strong certificate of need of limitations, we don't see any growth in those areas.

Your first question?

MR. GEORGE MILLER: Do you see a difference --

MS. KELLEY: Oh, on outcomes.

MR. GEORGE MILLER: On outcomes with the same diagnosis, especially with those patients in areas of the country that have no LTCHs or never go to an LTCH versus those that go to an LTCH.

MS. KELLEY: There have been a lot of studies over the past several years trying to answer that question. MedPAC did some work back in the early 2000s, and CMS has done a lot of work in this area.

And we, in our work -- and other researchers as well -- have not been able to find real differences in outcomes by at least looking in terms of readmissions and

mortality rates and sort of gross measures that we had.

The care demonstration allowed for the first time to sort of collect all that information about LTCH patients in order to try and compare them more accurately with other patients.

And in the care demonstration as well, there was very little difference in outcomes. The only difference that was seen was in hospital readmissions within 30 days of discharge from the acute care hospital.

Of course, LTCHs are certified as acute care hospitals. So one would expect that they would be able to handle problems that a SNF or an IRF or a home health agency couldn't handle.

It was also found in another study, using the care tool, that 30 days after discharge from the LTCH readmission rates were higher for LTCHs. So -- and that likely speaks to the sickness of the patient population.

MR. GEORGE MILLER: Yeah, yeah. And just one final quick question -- what is the average length of stay for an LTCH?

I know it's a minimum of 25 days, but what ends up being --

MS. KELLEY: The average length of stay is about 25 -- 24 days, but it does vary -- shall I show my slide?

It does vary by diagnosis.

And this is sort of an interesting thing I did. This is the top two diagnoses. 207 is prolonged mechanical ventilation, and 189 is pulmonary edema and respiratory failure. And you can see that there is a wide spread in lengths of stay. The number of cases there is on the vertical axes.

MR. GEORGE MILLER: Right.

MS. KELLEY: You see that big climb up there. Now you might think that that was 25 days, but it's not, if you look down below.

MR. GEORGE MILLER: Yeah, yeah.

MS. KELLEY: What that is, is the short-stay outlier threshold.

MR. GEORGE MILLER: Oh.

MS. KELLEY: So once the case gets past -- every DRG has its own short-stay outlier threshold, of course, based on the average length of stay for the DRG.

So once we get past that point, we see it does have a significant impact on discharge.

MR. GEORGE MILLER: Thank you.

DR. SAMITT: So I have two questions.

Going back to -- what slide was that? Eight, I think.

As a big believer -- it's the next slide. I'm sorry.

MS. KELLEY: Nine?

DR. SAMITT: Nine. As a big believer in prospective payment, I was very surprised to see this graph. And, I just didn't understand the methodology for payment adjustments between 2003 and 2005, in particular -- a nearly 25 percent increase in prospective payment. What was the basis for that back in those years?

MS. KELLEY: When the PPS was first implemented, of course, it's based on previous payment. You know, it's based on analysis of what previous payments were and claims data to assess what payments should be in the first year of the PPS.

A major problem that we have in moving from cost-based reimbursement to prospective payment -- and I think, as Glenn said, we've seen this in every PPS, including the acute care hospital PPS -- is that when cases are paid on

the basis of costs there's not much motivation to code specifically.

When you move to a PPS that's based on diagnosis, there's a big change in coding. And we've seen that. Obviously, you've talked about that with the acute care hospital quite a bit in the past.

So some of this is simply a big increase in documentation and coding improvements that results in growth in payments and case mix. Some of it is because of the way the TEFRA system operated.

Remember, TEFRA was put into place in 1983 as a very short-term fix before PPS -- or 1992, before PPS was implemented for acute care hospitals. And then, it went on for these excluded facilities -- LTCHS, IRFs, psychiatric facilities, et cetera -- much longer than it was intended.

And, over time, there were some really perverse incentives under TEFRA that favored -- greatly favored -- new facilities and encouraged new facilities to open up, operate at very high cost levels in order to establish a high-cost basis and then, going forward, to ratchet down their costs but keep -- their payments would be based on that initial high-cost basis.

So there is a sense that the aggregate payments that were used as a basis to establish what payments should be, in a budget neutral fashion, under the PPS, were probably too big.

And so, over time, CMS has tried to -- has made adjustments for documentation and coding improvements. They've made changes to the way they pay for short-stay outliers, which were certainly too generous in the early years of the PPS. And they also made adjustments. They put in something called the 25 Percent Rule for hospitals -- LTCHs that operate within acute care hospitals -- that prevented them from admitting more than a certain share of their patients from that one hospital.

DR. SAMITT: Great.

DR. CHERNEW: I just want to add one thing conceptually.

A lot of times when you see graphs like this it's tempting to think that the cost trend is sort of predetermined. If PPS is working, by definition, the incentives would require the institutions to hold the costs down below what their payments are.

So all the things that Dana said, I think, are

exactly right, but you shouldn't look at a deviation between the actual cost trends and the payment trends as a sign that the payment trends were too high. You might look at something like this and say, oh, the incentives are working.

The real question is you'd want to know what would the cost trends have been had they still been paid costs. And that, we don't know.

So there are all the things you said, I think, matter exactly, and there's all kinds of coding, and there's base cost things that get messed up. It's our job to think about it in our update stuff. But just because you see this gap doesn't mean evidence that PPS was doing a bad job.

MR. HACKBARTH: So it sounds like you're focusing, Mike, on the gap between the blue line and the yellow line.

PARTICIPANT: I'm looking at the slope [off microphone].

MR. HACKBARTH: The other striking thing is the change in the yellow line with the implementation of PPS. Forget the blue line.

DR. CHERNEW: Right [off microphone].

DR. BAICKER: So what you'd like to see is the green line that had been forecasted --

DR. CHERNEW: Right, right [off microphone].

DR. BAICKER: That had been forecasted in 2001, which might or might not have been correct, but would give you a sense of how the curve had potentially bent relative to what you had anticipated it to be.

DR. CHERNEW: That's true.

DR. MARK MILLER: And the other two lessons I would draw from this. and the second one you guys may agree or disagree with, but keep this in mind because this keeps showing up all over the place. Was the base rate set right for home health? Was it set right for SNF? You know, dialysis just went into PPS. We're starting to see some shifts in the trend, and so we need to keep an eye on this. And this is, of course, a comment that comes up all the time. We're always chasing our tail. This is why we need to get to different payment systems, and that's another lesson to draw to this.

I also think you can look at this -- and you guys may disagree with this, but the other thing to keep in mind is where you set your payment may also drive your costs. And so that could be another indication here, although given all the -- there's, you know, the for-profit here, there is

a bit of a surprise that it follows it that closely, because the for-profits tend to keep their costs down relative to not-for-profit.

MS. KELLEY: But the other -- I'm sorry.

DR. SAMITT: That was the basis of my question because I look at this and I presume that the cost line is following -- the green line is following the blue line as opposed to the other way around. And so that's the concern that, you know, perhaps we were overly generous in that methodology, allowing the freedom of cost expenditure in these settings.

MS. KELLEY: I think the other thing to keep in mind that might be reflected in the cost line here is that when the LTCH PPS was put into place, we had a large growth in the number of hospitals within hospitals, and their costs we could see were higher, you know, for a number of different reasons. And so some of that may be driving the average cost there, and as now hospitals within hospitals have sort of -- growth has completely halted and, in fact, there have been some closures in hospitals within hospitals. And so that may have caused some of the flattening you see, too.

DR. SAMITT: I have one other quick question, and that's on Slide 11. Do you have an understanding of the difference between the high-cost outlier between high margin and low margin? I guess my question is: Is there a patient selection effect here, or what is the reason for this major difference?

MS. KELLEY: Several in the industry will tell you there is a case-mix difference here. It's very difficult to sort of get under what's going on here. There is not a big difference in case mix, at least in terms of the DRGs themselves, so there is -- the high-margin LTCHs do tend to take care of the more higher -- of the higher sort of acuity cases, but they either -- you know, for whatever reason, they care for them in a shorter period of time, or they have -- you know, they've selected a less severely ill -- it's hard to say what's going on there.

DR. SAMITT: Okay.

DR. NERENZ: A couple of quick questions. If you could just toggle quickly between 3, 5, and 6.

[Laughter.]

DR. SAMITT: Every few seconds or what?

DR. NERENZ: You don't have to keep spinning it.

There's clearly an inflection point in '05, and it's up on the slides as well. PPS started in '03. The moratorium was very late '07, effectively '08. You've made mention of just changes generically in '05 in that period. What specifically or is there something specifically in '05 that we should think about? Because clearly that year something happened there.

MS. KELLEY: Yeah, two things I think are relevant here. First is the 25-percent rule that I mentioned went into effect, and that prohibited -- it limited the share of cases that a hospital within hospital, so an LTCh established within an acute-care hospital, could admit from that one hospital. So prior to 2005, there was a big advantage, I think, to acute-care hospitals having an LTCH in their hospital. After 2005, the advantage of that declined because they couldn't move as many patients to the facility.

The other thing that changed about that time was CMS began to ratchet down on what were, I think, clearly overpayments for short-stay outlier patients, and so that, too, I think, reduced -- everything's relative, but it reduced the attractiveness of having an LTCH and anything

that sort of reduced the aggregate payment there.

DR. NERENZ: Okay. Then if you could just back up one to Slide 4, just for information, we talk about the other settings. What are the other settings? And do we have data that let us know what the distribution of CCI patients is in these other settings?

MS. KELLEY: So the other settings that we've typically talked about are the other post-acute care settings, particularly SNFs, especially now that we have the compliance rules for IRFs that really limit -- as we talked about before, it may be a very ill person, but it's certainly not a frail person, if you will, who goes into an IRF. So the other settings that might be comparable to an LTCH are SNFs, but especially acute-care hospitals.

DR. NERENZ: That's exactly what I wondered, because it seems like there's both an up and a down option in terms of the acuity of the alternative, and I'm just curious. What do we know about the distribution across those alternatives?

MS. KELLEY: Well, I do have a slide that I put here just in case we had a question about t his. So this is some work that Julian Pettengill and I have been doing, and

this looks at -- so these are discharges from 2010 from acute-care hospitals, and we've got three bars here: one is patients who had less than four days in an ICU or a CCU, the middle one is four to seven days, and the right-hand bar is eight or more. And this shows the discharge destination for these patients.

Patients who did are not included here, so the other setting is either they went -- it's basically they went home. Some of them may have gone to home health as well. The red, as you can see, is SNF and IRF. The yellow bar is LTCH, and the blue -- oh, I'm sorry. Died is on there. I'm sorry. Died is in blue.

So you can see, you know, there's -- I think this sort of shows the severity of illness aspect of it, but also shows that, you know, patients do go to various different settings.

DR. NERENZ: Okay. So the acute hospital as an alternative is part of the green, but it is not all of the green.

MS. KELLEY: Well, the acute-care hospital here wouldn't -- this is the discharge destination, right? So --

DR. NERENZ: So they have all left.

MS. KELLEY: Yeah.

DR. NERENZ: But some could stay.

MS. KELLEY: Sure. And, in fact, in your eight-plus column, you're likely to have, you know, the longer acute-care hospital stays.

DR. MARK MILLER: I think you are asking the right question. I think. Depending on whether you were headed with it. I mean, one of the things I think that we grapple with and what Dana and Julian are thinking about right now is, you know, in the areas where there is not this option, then the hospital deals with it. And so, you know, the equity in the payment system between those two scenarios is something that we're trying to think about. There's kind of the LTCH payment itself, and then, you know, we have to deal with it in silos because of what we have to do this month. But in a broader sense, we're trying to think about how to alter this payment system in such a way that when the hospital is having to deal with this, there is some equity in that sense. So if that's where you're headed, there is some thinking going on.

MR. HACKBARTH: Yeah, so there is, as you say, Mark, an equity issue, but there's also -- it seems to me

there may be a question of whether it might be a lower-cost option for Medicare to have them stay a little bit longer in an acute-care hospital in a more robust outlier payment to accommodate that as opposed to them going to a new institution and triggering a whole new episode of payment.

DR. NERENZ: That's what I was wondering about.

DR. MARK MILLER: And that's what we're trying to think through [off microphone].

MS. KELLEY: I think the work that we've done in the past and CMS' work has confirmed this as well, that when we looked at patients who used LTCHs and compared them with similar patients who didn't and we looked across the episode of care, so different settings, we found that Medicare pays a lot more for kind of the lower-acuity patients who use LTCHs than Medicare would if they had not used an LTCH. But for the highest-severity patients, the differences really narrowed. And so I think that's one of the reasons why we've been thinking about trying to identify who are those very high acuity patients.

MR. HACKBARTH: Yeah. That piece of research that Dana just described was something we did a number of years ago and was one of the foundational pieces for our

recommendation that what we needed to do was establish patient criteria on who it made sense to pay this much higher level of payment for as opposed to open-ended criteria on who goes into an LTCH, could we make sure this expensive resource was really focused on the people who would most benefit from it. But that approach of narrowing patient eligibility has just never come to fruition for a number of --

MS. KELLEY: One thing we've been looking at -- and I put up the slide here about developing LTCH criteria, and this is something I know that CMS is working on as well, and there's more and more literature about the CCI patient. And, you know, sort of just focusing more on trying to figure out who they are, and these are some definitions that have been put forth from a number of different sources. So these are the kind -- and you saw that Julian and I were looking at the use of intensive care services. So these are some of the kinds of things we're exploring.

DR. BAICKER: Just following up along those lines, in several different contexts, we've heard about potential alternative paths for patients' post-acute care, and we've got bits and pieces of information about the characteristics

of patients in this setting and the characteristics of patients in that setting. Going forward, not necessarily for this update decision, it would be, I think, helpful to sort of lay out the overlapping patient populations in the different settings and the outcomes as were measured. I heard in the introduction about how they're not yet measured consistently across those settings, but understanding the fungibility of patients across settings based on their characteristics would be really helpful in thinking about how to harmonize these. That's just a future data request.

MS. KELLEY: In the short term, I think the results from the CARE demonstration might also inform that consideration. So that's something I can summarize and bring to you for next time.

MR. HACKBARTH: Okay. Peter, what I'm going to suggest is that from the rest of the way, why don't you, in addition to asking any clarifying questions you have, also let us know what you think about the recommendation and combine Rounds 1 and 2 the rest of the way around to make up time? Is that okay with you?

MR. BUTLER: Okay.

DR. MARK MILLER: [off microphone].

MR. BUTLER: I'm ready. We're just getting more data in on outcomes and so forth. Overall -- and you loosely mentioned mortality rates, for example, so in a hospital it may be 2 or 3 percent, and you've already demonstrated in, for example, that previous slide that over 10 percent of the ones that are coming from -- what's the overall mortality rate in LTCHs? Do you know?

MS. KELLEY: I do.

MR. BUTLER: Because it's just a whole -- it's a totally different exercise.

MS. KELLEY: It varies quite a bit by diagnosis. There is -- I thought I had it right here.

Off the top of my head -- I don't want to misspeak -- it varies quite a bit by diagnosis, and -- oh, I know what I did. I looked at cases that were very short-stay outliers compared with cases that were not short-stay outliers, so eliminating the kind of middle short-stay outlier cases, and one of the things that varied tremendously was the mortality rate. So for the patients who stay sort of beyond -- who have sort of the longer regular LTCH stay, the mortality rate in facility was quite low. It was about 7 -- for a sickly population low, 7

percent. For patients who had the very shortest stays, most of them -- or 40 percent of them die in the LTCH. So there is a -- the shorter-stay patients do tend to -- are much more likely to die in the facility. Within a year following discharge from the facility, many of these -- almost half of these patients have died.

MR. BUTLER: Well, this slide here that you have up, it's stunning that -- also in the chapter it says that if you're transferred with mechanical ventilation, 69 percent die within a year.

MS. KELLEY: Now, that was not based on our analysis. That was another study.

MR. BUTLER: Right, another study that did suggest that these --

MS. KELLEY: But it's very striking.

MR. BUTLER: -- are obviously sick people. And how palliative care and hospice care fits in and kind of -- you know, and how that is embraced or not is -- this is -- now I'm going to start sounding like a death panel or something. I don't want to do that, even though I use those words. But now that I've done it -- but I have no doubt that the literature -- the study suggests that if you're in

an area where there's significant population, that having a critical mass of -- being able to do particularly ventilation in a dedicated unit that has a significant population can be done efficiently and effectively, better than in ICUs in the hospitals that are spread all -- so I'm supportive of the concept.

So one other just comment that strikes me. Yesterday we looked at home health and said there are 12,000 home health agencies, you know, a little bit of everything, and they're a key part of -- and here two companies have over half of the business. So it just strikes you -- and they're for-profit. It just strikes you, two very different kind of approaches to key parts of the post-acute world, and you're going to get different approaches. The for-profits are more responsive to short-term incentive and opportunities, plus and minuses. They manage more tightly, et cetera. But I think they're just so different cultures. I think we need to think about that, too, and who the -- you know, how this post-acute spending evolves. We're big believers in a pluralistic system here in the country, yet we're kind of making decisions ultimately that really could put these things in hands that maybe are good or maybe are

not. It's just something we need to think about. And I'm supportive of the recommendation.

DR. CHERNEW: I'm good on the recommendation.

MR. KUHN: A couple quick comments, one picking up a little bit where Peter was asking, one of the things LTCHs talk a lot about is their ability to wean patients off vents. How does their performance compare to SNFs or to ICUs or others? Are they that materially different?

MS. KELLEY: I don't know how they compare to ICUs. I think it's fair to say that there are very, very, very few SNFs that will take ventilator patients these days. So I suspect, you know, they're -- I don't know what their weaning success would be, but I think there are very few of them that do it at all.

MR. KUHN: Okay. Thank you.

MR. HACKBARTH: So, Dana, in places on the map where there aren't LTCHs, the ventilator patients are just staying in the acute hospital?

MS. KELLEY: They stay in the acute-care hospital for the most part, although -- and some -- there are LTCHs that do serve, you know, much more of a regional and even national population. There are LTCHs that take patients

from around the country and, you know, one would presume that many of those patients come from areas where there aren't LTCHs or don't have LTCHs that have, you know, the name recognition that some LTCHs do.

MR. KUHN: Thank you. A second quick question, again, going back to Peter's query about the mortality rates. I, too, have been very curious about this over time. When CMS made the policies on the short-stay outlier, did that change the classification of those patients much? Did we see any movement, I guess, in the mortality rates for short stays when that policy went into place? Because I think the concern when that was put in place was that LTCHs were being used as a very high cost hospice, and there was an attempt to try to kind of manage that. So did that policy have the intended effect?

MS. KELLEY: I would have to look at that more closely. The strange quirk of the short-stay outlier policy is that the formula is such that about 30 percent of patients are always going to be short-stay outliers. So it's a moving target.

The new very short stay outlier payment policy, which effectively limits payment to an IPPS, you know,

similar rate for the shortest-stay patients is not linked in the same way. And so it will be interesting to see whether the changes in payment do affect admission of those patients.

I think CMS' feeling is that the shortest-stay patients who die so quickly, similar to what Peter was saying, that moving these patients so late in the course of their life is disruptive to them and to the family, and that a payment policy that encourages that movement is maybe not in the patient's best interest. And certainly to the extent that the cost of caring for the patient is so much lower than average, it's not in Medicare's interest as well.

MR. KUHN: Thank you.

And then a final quick question here. On the 25-percent rule, and when that was put in place in '05, when -- and I'm trying to remember. What was MedPAC's position on that rule at that time? Did they support CMS in that? I think MedPAC was more kind of in the patient criteria classification.

MR. HACKBARTH: Exactly. We saw the 25-percent rule as distinctly a second-best option.

MR. KUHN: That's what I recalled. I just wanted

to be sure if I remembered that right.

MS. KELLEY: We did encourage CMS, however, if they were going to have a 25-percent rule, that it be applied across the spectrum of providers and not just to hospitals within hospitals, because increasingly -- and you'll note in your materials this year that I didn't even break out hospitals within hospitals and free-standing facilities because increasingly it's very difficult to tell the difference between the two. Is an LTCH that's across the street from a hospital different from one that's on the second floor of a hospital? And certainly I can't see differences necessarily in their margins, in their costs, in their -- you know, it doesn't seem to be a meaningful distinction, and so we did encourage CMS, if they were going to have a 25-percent rule, that it should be applied uniformly.

MR. KUHN: Thank you. That's helpful. And I did notice that distinction, that the hospital within a hospital is not in this set of materials. I was curious why, so thanks for the explanation.

I do support the recommendation.

MR. HACKBARTH: And you were one of the authors of

the 25-percent rule.

MR. KUHN: I remember it well.

[Laughter.]

MS. UCCELLO: Can you remind me where these patients are coming from? Are they all or nearly all post-acute hospital, or are they coming from anywhere else?

MS. KELLEY: About 81 percent come directly or within three days from the acute-care hospital, and the rest do come from the community. The community admits look very different and predominantly fall into DRGs such as pressure sores, you know, they tend to be more of the skin DRGs and wound care, and much less respiratory diagnoses.

MS. UCCELLO: And so this wound care, because that leads to another question I had on the increase in cases with infections. These are coming from the community or--

MS. KELLEY: No. The information I put on infections in the chapter, those are all patients, so it's not just community patients.

MS. UCCELLO: Okay. So are those infections at admission or just -- so are these indicating poor quality in other settings, aside from any coding?

MS. KELLEY: Sure. The research is showing that

there are much -- quite a bit of growth in the admission -- of patients admitted with existing infections, so, yes, they are coming from other facilities. There's very great regional differences because in any particular region there will be different infections circulating in hospitals. But for the most part, we are seeing a big increase in patients who are admitted with infections.

It's hard to tell whether -- it's hard to differentiate, however, patients who -- from the data, from the claims data patients who acquire infections in the LTCHs from patients who had them when they were admitted. So my information about the increase in admissions with infections comes from smaller analyses that were done and published in the literature.

MS. UCCELLO: Thank you. I support the recommendations and again reiterate the concern here is that, you know, we really need to think about all of these different settings together.

DR. DEAN: The bar graph that you showed of where patients were discharged to, that's nationwide data, right?

MS. KELLEY: Yes.

DR. DEAN: Because it would seem that it's

probably affected because in some areas LTCHs are easily available, others places they're not available.

MS. KELLEY: Oh, sure.

DR. DEAN: I would think that would really have an impact on this data.

MS. KELLEY: Yes. We can try to break --

DR. DEAN: I don't know if there's a way to break it down --

MS. KELLEY: -- that out regionally. We might be able to do that. We will look into that.

DR. DEAN: Okay. What about -- maybe it's in here and I missed it, but the payer mix between for-profit and not-for-profit facilities, is there a difference there? I suspect there might be?

MS. KELLEY: Not as much as you would think. For both types of facilities, Medicare is close to half of their revenues, and often the for-profits have a higher share, a slightly higher share of Medicaid patients.

DR. DEAN: Do they really?

MS. KELLEY: Yeah, so it's not what you would expect necessarily.

DR. DEAN: Okay.

MS. KELLEY: Although they may -- I suspect that the nonprofits may have a higher share of uninsured patients.

DR. DEAN: Okay. All right. Thank you. Interesting, for all these same reasons. We've got this whole collection of different kinds of providers doing -- and a lot of overlap between what they do, and we really need to rationalize that somehow.

I support the recommendation.

MR. HACKBARTH: Okay. Alice?

DR. COOMBS: So I agree with just being able to drill down to a granular level as to what the -- the difference between the nonprofits and the for-profits have in terms of the clinical diagnosis.

I just want to add to the infections, Cori, the infections that are happening now are a little different. There are those acquired infections from the decubiti, but if they come from the hospital -- some of them are actually wound infections that are on vacs --

MS. KELLEY: Sure.

DR. COOMBS: -- and when you have a physician on a wound infection with a vac, it really actually is a very

costly endeavor for these patients in this venue.

In terms of the ventilation, in terms of the success, I was so glad to hear you, Dana, say you didn't know, because we don't know, and I'm in the critical care area, as to how well these people do, and it really is variable in terms of them going to an LTCH that kind of really, really specializes in vents and being able to do a lot of different innovations to try to wean people off the vents.

I think that when you look at the for-profits, one of the things that comes to mind for me is the very type of patients in terms of comorbid conditions. For instance, there are some that would probably incorporate some of the quads, who is very labor intensive, and in terms of not only having respiratory failure, but, you know, the combination of wound care as well as some even need to be on dialysis. And dialysis in and of itself, when I get ready to place a patient, it makes it very difficult if the patient is on dialysis and on the ventilator at the same time.

MS. KELLEY: I've heard that from others, as well. That is a very difficult --

DR. COOMBS: So you only have a very, very few

number of LTCHs within a given region that can do both vents and dialysis at the same time, and that's really a struggle.

I support the recommendations.

DR. REDBERG: Excellent presentation. My concerns about this -- you know, for the other post-acute care that we've looked at, I felt like they were really helping our beneficiaries and we just had to kind of think about allocation being wiser. I'm not convinced that LTCHs are actually helping our beneficiaries at all because there are parts of the country where they don't have any and I haven't heard any indication that beneficiaries are doing any worse in those parts of the country. The mortality rates, we didn't see any data on improved outcomes. And if you look at the mortality rates of patients from the literature, it's that survival is less than ten percent for patients with two organ system failure. That was cited in the --

MS. KELLEY: Right. That's not our work, that's --

DR. REDBERG: -- in the reading material.

MS. KELLEY: Right.

DR. REDBERG: Right. I understand. And certainly, I mean, in my clinical experience, that is true,

and the weaning rate is very high.

And so I just wonder whether we should be looking at sort of the big picture, if this is the right way to be spending Medicare resources, because I don't think that this is a population we're helping by long-term -- we're just -- as Herb said, it's kind of a very expensive hospice care. You know, I think a lot of the end-of-life spending that Medicare spending is probably going into LTCHs and people aren't getting better.

And so a lot of this might be related to the lack of end-of-life discussion planning issues. If patients understood they were going to go be on a ventilator in a long-term care hospital or their families understood, for many, many months, and then still die, I'm not sure people would choose that because that's not really, I don't think, in our beneficiaries' interest.

And so I have a lot of concerns about this use of Medicare resources because I don't see the benefits to patients. And clearly, things are -- I mean, some of those are related. I think people that are on long-term vents are more likely to get pressure sores, of course, because they're not moving because they're on a ventilator. They're

more likely to get infections because they're in an ICU or in a hospital with multiple lines that get antibiotics. I'm sure MRSA has become a big part of that, and we're just seeing more and more. And as our population ages and has more and more comorbidities, I think this is going to be a growing part of the demographic and something that we really need to pay attention to.

You did note in the mailing materials that there were some outlier payments for patients who are extraordinarily costly. Are there any particular areas that lead to outliers, or are they --

MS. KELLEY: I'll have to get back to you. Do you mean by diagnosis or -- I'll have to get back to you on that. I have done that work. I, just off the top of my head, I --

DR. REDBERG: So I support the Chairman's draft recommendation, although I will note that, once again, I think the Chairman may have been overly generous in this recommendation.

MR. ARMSTRONG: You know, interestingly, I was going to go down a similar path to the one that Rita just went down. I assume that if there wasn't a payment category

for long-term care hospitals and we just paid at the acute care hospital rates, it would cost the program much more. Is that correct?

MS. KELLEY: It would cost the program more?

MR. ARMSTRONG: Yeah.

MS. KELLEY: If there weren't an LTCH?

MR. ARMSTRONG: If we just paid -- I assume -- let's assume the vast majority of these services will have to be provided in some other setting --

MS. KELLEY: Mm-hmm.

MR. ARMSTRONG: -- and that a lot of them would be in the acute care hospital --

MS. KELLEY: And become outliers in the acute care hospital?

MR. ARMSTRONG: Yeah. Would that be a much more expensive --

MS. KELLEY: No, I don't think it would. I think it would be less costly, even if there were outliers in the hospital.

DR. COOMBS: I can respond in that I'm a critical care doctor and it would be incredibly expensive for --

MS. KELLEY: For the hospital.

DR. COOMBS: No, for Medicare --

MR. ARMSTRONG: That's what I meant.

DR. COOMBS: -- to actually pay, because you're going to be paying for vent care. In some hospitals, they don't have a step-down unit and the patient wouldn't go to the floor, so that you're going to be billing for an ICU rate.

MR. ARMSTRONG: Yeah.

MR. GEORGE MILLER: It's a DRG.

MS. KELLEY: Right.

MR. GEORGE MILLER: It's going to cost the system less. The hospital is going to lose a gazillion dollars.

DR. COOMBS: Right. Well, that's true. That's true. The hospital will lose money --

DR. DEAN: George picked up on that right away.

DR. COOMBS: The hospital will lose money --

[Laughter.]

DR. REDBERG: Very well said, George.

DR. MARK MILLER: Run the gazillion down.

[Laughter.]

DR. MARK MILLER: This comes back to this discussion over here that I think might have triggered --

with David -- of thinking about how the allocation between these two sectors might be more fair, and so keep that thought in mind. I'm sorry, Scott.

MR. ARMSTRONG: Yeah. I just -- it really was striking me that I wonder if it would be worth just modeling out, what if this payment category just didn't exist, and if that would -- what the implications, both in terms of how care systems are organized, but the cost to the program. That's probably more than we could do if it hasn't been done already before we make these decisions in January. But it just -- you know, we're sort of waiting for the integration of post-acute care bundles and maybe there's other ways of simplifying this by just taking out certain payment categories in the meantime.

DR. HOADLEY: I'd just make a quick comment back on this last point. I mean, I think it's really interesting, and some of the qualitative stuff I did a few years ago -- the opportunity to compare areas that do and don't have them actually makes some ability to think about that more than just as a calculation, and we certainly talked to people about what happens to these patients and there are some opportunities there.

Yeah, I'm supportive of where we are in this, but obviously -- you know, this, I think, has been a really good discussion and there's a lot of bigger issues around this.

DR. NAYLOR: I also support the recommendation but would like to follow up on -- and I think that this path that you're taking is exceedingly important, taking a look at what the experience is like for the people who are spending a long time in ICU, then going to an LTCH and dying within 25 days, I mean, just understanding, because it's not the same category of people that goes from a short-term and spends nine months in a facility and has a positive outcome. So I think uncovering and unbundling who they are.

And it would lead me to think that real opportunity here is -- especially when you're seeing the growth in diagnosis around respiratory, end-stage respiratory, et cetera, is to really think about the kind of investment we need to be making in palliative care, in hospice, and not extending hospital care but rather early identifying a population that could benefit from entirely different services.

Let me also say that in home health, there's a report out very recently that looked at what people are

experiencing and the amount of ventilator care, for example, and medical and nursing tasks that family caregivers are now being asked to do without any investment in them. So over 50 percent reported that they have huge tasks, including ventilator care, managing complex medications and other therapies, and nobody has prepared them for these things.

So I think that there are many sides to this and many alternative paths. I would agree with the thought that we should really try to unbundle who is it that shouldn't be in this service at all and would benefit from a higher quality of life and a higher quality dying without it.

DR. HALL: I'm in favor of the recommendations.

MR. GEORGE MILLER: Yes. I think Rita teased out what my original question was about the fact that it's a better quality of care if there are better outcomes with or without the LTCH. So based on that, in general, I support the recommendations, but I think the question has been raised: Is this the best use of the Medicare fund program, particularly with this particular segment of the population. And the question really in my mind is not if this didn't exist, as Mary was just outlining. Are there better alternatives to use of the dollars more wisely, especially

with the current outcomes that we know.

The fact that health care has evolved and changed over the years with technology, we may need to go in a different direction. That's a bold statement for MedPAC to make, but maybe we should make that statement.

DR. SAMITT: I'm thinking in the general direction of where Rita and Scott were. You know, although I recognize Scott's desire to do some modeling around what life would be like without this payment category, but my interest is really to understand whether LTCHs do offer beneficiaries higher quality outcomes in a more efficient manner. If they don't, then I would actually think that this recommendation is generous. If we feel that that is not the right ultimate setting -- the payment barriers aside -- for beneficiaries at end of life, then I think to offer a scenario where there are such great margins is really a disservice to Medicare.

However, if they do offer an advantage in some ways, then I would preserve the recommendation as is, and I don't know if there's a way to get at that answer, but I'm struggling with this. I think, at a minimum, I think the recommendation is good,. It may border on generous if the

use of this forum does not make sense for beneficiaries.

DR. NERENZ: I support including with some of the caveats that Craig and others have made.

DR. BAICKER: Yes, I'm supportive, as well.

MR. HACKBARTH: Okay. Thank you very much, Dana. Excellent job.

So we are now roughly a half-hour behind schedule. I think that probably means that we're going to run over by about 15 minutes for Commissioners. Does that pose a problem for anybody in terms of plane or train schedules?

[No response.]

MR. HACKBARTH: Okay. So we'll try to move as quickly as possible, but I do think we'll run over a little bit, and George, my apologies for that.

Okay, Kim.

MS. NEUMAN: Good morning. So we're now going to talk about hospice.

The Medicare hospice benefit provides palliative and supportive services for terminally ill beneficiaries who choose to enroll. By enrolling, the beneficiaries agrees to forgo curative treatment for their terminal condition.

In 2011, over 1.2 million Medicare beneficiaries

used hospice care and received it from over 3,500 providers. And Medicare spending totaled about $13.8 billion.

So I have a couple slides with some background on hospice and the Commission's prior work and recommendations in this area. In the interest of time, I'm going to try to go quickly through this, but I'm happy to address questions.

On this first slide, we just note that when the benefit was implemented in 1983, it was done so on the presumption that hospice would be less costly than conventional end-of-life care. And so the Congress placed two constraints on the benefit and eligibility criteria. The benefit is for patients who have a life expectancy of six months or less, and there is a cap on the amount of payments an individual provider can receive each year. It's a limit in the aggregate on the average payments, a little less than $24,000 per patient on average.

This next slide reviews the Commission's work. In 2008 and 2009, the Commission looked at hospice in depth and found some notable trends. From 2000 to 2007, we saw an increase in the number of hospice patients, nearly doubling over eight years; Medicare spending more than tripled over the period; the number of providers grew by almost 45

percent, mostly for-profit providers entering the market. Average length of stay increased by about 50 percent, driven by increased length of stay for patients with the longest stays. And we saw for-profits having longer stays than nonprofits.

We also had information from a panel of hospice physicians and executives that gave reports of lax admissions practices and recertification practices among some hospice providers and also concerns about questionable financial arrangements between some hospices and nursing homes.

So this led us to look at the hospice payment system, and we found evidence that the payment system is not well matched with the intensity of care throughout an episode. Medicare makes a flat payment per day (whether a visit is provided or not), and hospice service intensity tends to be greater at the beginning of the episode or at the end of the episode near the time of the patient's death. So as a result, long stays are more profitable than short stays.

This led the Commission to make a recommendation to reform the payment system to make it better aligned with

intensity of care throughout an episode. This is the U-shaped curve recommendation. And PPACA gave the Secretary the authority to revise the payment system in 2014 or later, as she determines appropriate. So it's not clear what will happen here, and we have a standing recommendation for payment reform in this area.

We also made a number of accountability recommendations. I'm going to touch on two quickly. The first is the face-to-face visit requirement. Medical directors told us that it was sensible when a hospice patient reached 180 days to have a physician or nurse practitioner visit that patient before determining whether they continued to be eligible. And so that led to the face-to-face visit recommendation, which PPACA adopted and was implemented in 2011.

One other thing of note is that we heard from hospice medical directors that there were some hospices that were admitting patients with little regard for the eligibility criteria, and they suggested that focused medical review target providers with unusual utilization patterns. And so the Commission made a recommendation for focused medical review. PPACA adopted it effective January

2011. But that recommendation has not -- or that provision has not been implemented by CMS, so we continue to have a standing recommendation there.

So, with that, that brings us to our latest data and our framework, which we've used across the sectors.

This first chart shows the change in the supply of hospices, which has increased since 2000. That green line is the total number of hospices. You see over 1,300 new providers since 2000. And the yellow line is the number of for-profits. So the growth in the total providers is driven largely by the growth in for-profits, and that has continued in 2011.

The next chart shows the increase in hospice use among Medicare decedents. What we see is that in 2011, 45.2 percent of decedents used hospice, up from 44 percent in 2010 and up from about 23 percent in 2000. And this suggests greater awareness of and access to hospice services over time.

Across a wide range of beneficiary characteristics (age, race, urban/rural, gender, fee-for-service/managed care, dual and non-dual eligibles), hospice use among decedents increased between 2010 and 2011.

As we've seen before, minorities and beneficiaries in more remote counties have lower hospice use rates than other beneficiaries, but hospice use has been growing among all of these groups.

This next chart shows the growth in the number of hospice users, exceeding 1.2 million in 2011, up about 5 percent from the prior year.

Average length of stay among decedents, which grew from about 54 days in 2000 to 86 days in 2010, held steady at 86 days in 2011.

The average length of stay growth we've seen since 2000 has been primarily growth in length of stay among the longest stays. The 90th percentile in length of stay grew from 141 days in 2000 to 241 days in 2011, although growth has slowed in recent years. Length of stay for shorter stays has been relatively stable, as you see. The median length of stay was 17 days for most of the decade; it edged upward to 18 days in 2010 and returned to 17 days in 2011.

As we've talked about previously, both very short stays and very long stays are a concern. With very short stays, there's concern that the patient doesn't get the full benefit that hospice has to offer. And with long stays,

especially when it's concentrated among certain providers, the concern is that there may be some providers pursuing a business model that seeks to maximize profit by enrolling patients likely to have long stays or in the extreme case enrolling patients that do not meet the eligibility criteria.

So with this next slide, I'm just going to take a step back for a moment and consider the latest length-of-stay data in the context of payment reform.

Some might say that the leveling off of length of stay growth means that payment reform is not needed. But that line of argument ignores a fundamental problem with the current payment system.

Inaccuracies in the current payment system make long stays more profitable than short stays, which make the payment system vulnerable to patient selection.

As shown on this slide, length of stay varies by observable patient characteristics like diagnosis and patient location. This means that hospices that choose to do so have an opportunity to focus on more profitable patients.

Consistent with that, we see for-profit providers

having substantially longer lengths of stay than nonprofits -- 102 days versus 69 days on average.

Selection issues distort the distribution of payments across providers, and opportunities for selection can only be lessened through payment reform.

So next we have a slide on the hospice cap. As I mentioned quickly at the outset, the hospice payments each year are capped for each provider at an average of $24,000, roughly, per patient. And in 2010, we estimate about 10.2 percent of hospices exceeded the cap. That's down from 12.5 percent in 2009. And for those that exceeded the cap, the amount that they went over the cap was less in 2010 than 2009. So this suggests that hospices are making adjustments in their admissions practices in response to the cap.

Next, on to quality. We don't have any data to evaluate trends in hospice quality. Per PPACA, hospices will begin reporting quality measures in 2013, and there are two measures. The first is an NQF-endorsed pain measure. The second measure is not a traditional quality measure. It's a measure that CMS created to get a sense of what types of quality indicators hospices currently track, which is intended to help CMS identify measures for the future. So

under the second measure, hospices will report whether they track at least three patient care quality indicators and what those indicators focus on.

Two more points on that. Hospices that don't report in 2014 will receive a two-percentage-point reduction in their update for 2014, and given the penalty and the scope of these measures, we anticipate high rates of participation and reporting in 2013.

So now on to access to capital. First, just to point out, hospice is less capital intensive than some other Medicare sectors. Overall access to capital appears adequate. Among free-standing providers, we have reports from for-profit chains that indicate generally strong revenue growth as well as investments via acquisitions of other providers or investment in new startups. This, along with the overall growth in the number of for-profit providers, suggests adequate access to capital for this group.

For nonprofit free-standing providers, information on their access to capital is more limited. Provider-based hospices have access to capital through their parent providers, and as we've heard in the other sessions, home

health agencies and hospitals appear to have adequate access to capital.

So this brings us to Medicare margins. We estimate in 2010 that the Medicare margin is 7.5 percent, up slightly from the margin in 2009. Note how we calculate margins. We assume cap overpayments are fully returned to the government, and we exclude non-reimbursable costs, which means we exclude bereavement costs and the non-reimbursable portion of volunteer costs. If those costs were included in our margins, it would reduce our margin estimates by at most 1.4 percentage points and 0.3 percentage points, respectively.

This next chart shows the distribution of margins across providers. Free-standing hospices have higher margins than hospital-based and home health-based hospices. And the lower margins of provider-based hospices are due in part to their higher indirect costs, which are likely inflated due to the allocation of overhead from the parent provider. If provider-based hospices had the same level of indirect costs as free-standing hospices, their margins would be substantially higher, and the aggregate Medicare margin across all providers would be an estimated 1.9

percentage points higher.

We also see from this chart that for-profit hospices have a higher margin than nonprofits, 12.4 percent compared to 3.2 percent. However, when we look at free-standing providers whose costs are not affected by overhead allocation issues, the nonprofit margin is substantially higher, 7.6 percent.

This next chart shows how margin vary by length of stay and site of service. In the left chart, you can see that hospice profit margins increase as length of stay increases, as we've noted. The right chart shows hospice profit margins as the percent of the providers' patients in a nursing home increases, and as you can see, hospice margins increase as hospices have more patients in nursing homes.

The Commission recommended the OIG study hospice care in nursing homes, and the OIG study found that hospices that focus on nursing homes tend to be more likely to be for-profit, enroll patients with diagnoses that tend to have longer stays, and require less complex care. And the OIG recommended that CMS cut the payment rates for hospice in nursing homes.

So this brings us to our 2013 margin projection. We start with the 2010 margin, and we take into account the market basket updates between 2011 and 2013, the phase-out of the wage index budget neutrality adjustment and other wage index changes, and additional costs related to the face-to-face visit requirement and other requirements. Based on these factors, we project a 2013 margin of 6.3 percent. One 2014 policy of note is that the wage index budget neutrality adjustment factor phase-out will continue and will reduce the 2014 payments by an additional 0.6 percentage points.

So, in summary, the indicators of access to care are favorable; the supply of providers continues to grow, driven by for-profit hospices; the number of hospice users increased; length-of-stay growth has leveled off; quality data are unavailable; access to capital appears adequate; the 2010 margin is 7.5 percent; and the 2013 projection is 6.3 percent.

So, with that, that brings us to the Chairman's draft recommendation, which reads: The Congress should eliminate the update to the hospice payment rates for fiscal year 2014. And the implications of this recommendation are

a decrease in spending relative to the statutory update. In terms of beneficiaries and providers, no adverse impact on beneficiaries is expected, nor do we expect any effect on providers' willingness or ability to care for Medicare beneficiaries.

And that concludes my presentation.

MR. HACKBARTH: Thank you, Kim, and I really appreciate your help in keeping us moving along. You spoke very quickly.

MS. NEUMAN: Sorry.

DR. MARK MILLER: Try and catch your breath [off microphone].

MR. HACKBARTH: Bill, do you want to lead off? And what I'd propose is let's do one combined round here. Any questions or comments, plus your thoughts on the recommendation.

DR. HALL: Well, as opposed to a couple of the other things we've talked about today, I think this is one venue of care that we need to actively support. The hospice movement since the year 2000 has really revolutionized -- not so much the quality of life but the quality of the last part of life.

I agree very strongly with the observations that there needs to be some corrections in payment, and, therefore, I'm very much in favor of the recommendations that you've put forward.

DR. NAYLOR: I also agree with the recommendation. I think the variance of margins by different type is something that, you know, you struggle with, hospital-based and so on, but that said -- and I was wondering if we -- so I support the recommendations, but in the modeling that's going to go on with maybe the LTCH work, if we could think about how hospice -- if hospice were to substitute for the eight days in the ICU plus -- I'm just connecting these dots. What would the costs look like for the Medicare program if you were to substitute one type of service like this for what's going on in ICU plus first 25 days of LTCH?

DR. HOADLEY: Yeah, I'm fine with the recommendation. I wanted to just talk for a minute about the short-stay and the long-stay kinds of issues. Just as a numbers person, looking at anything where the median and the mean are so disparate, you know, just is dramatic. And I guess one question is, in things like you have on Slide 10 where you show the mean lengths of stay for some of these

different categories, I wonder if this is a case where, rather than looking at the mean, there's some value in looking at the percentage of cases above some threshold of long stay. It might just get to the exact same results, but it might not. Just, you know, the numbers, when the means and the medians are so far apart, these could be really dramatically swayed by some extremely long cases, and it might just be worth taking a look and seeing if that -- or maybe you've already done that at some point.

MS. NEUMAN: Yeah, we do have that data, and I will have that for you next time. You know, we've looked at a percent of stays over 180 days, and it does -- it follows out in these general directions.

DR. HOADLEY: Okay. And I guess my other comment is on the short stays, and you talked about why that's a source of concern. Anecdotally, it seems like the cases that I've known from family members or friends that have been short stays are cases where somebody, you know, not because of any situation where there was necessarily a delay in making a decision to go forward, but some kind of a health situation that was sort of accelerating rapidly, and the decision was made, you know, no further treatment, go to

hospice, and then the person dies within 24 or 48 hours. It strikes me in situations where -- but, obviously, those are anecdotes. I don't know how common that is. But certainly there's a number of short-stay cases that would be completely legitimate, just the nature of how disease takes on. So I don't know that there's any way to ever try to measure that difference, but I just wanted to put that in there as a thought about how to think about this.

MR. ARMSTRONG: I, too, think this is an invaluable program. Given the margins, I think the recommendation is heading in the right direction.

Just one question. The percentage of decedents cared for in this program has gone up a little bit in the last year, it just makes me wonder. We think of that as a measure of success, but I just wonder if there's a target that we have for that, you know, if we think that there's like an optimal level, or are we getting close to that? Is that something --

MS. NEUMAN: Well, a target is hard. I think everyone agrees that it's never going to be 100 percent because of unexpected and unforeseen situations.

MR. ARMSTRONG: Right.

MS. NEUMAN: I can tell you that right now there's a range geographically, and we see that number as high as 60 percent in some areas. And when I hear people talk about the upper limit, you hear them throw around 60 or 70 percent. I don't know how much science is behind that, but it seems like there's more room to go in the aggregate, I would say.

MR. ARMSTRONG: I would like an opportunity in the months ahead to talk a little bit about what are ways in which our payment policy might encourage that number to get higher than -- get closer to 60 percent, you know, more consistently. But I want to affirm I support the direction the recommendation is going.

DR. REDBERG: As a clinician, I would suggest -- first I'll say excellent report, and I'm very supportive of the hospice program, and my patients and their families, the only thing they say to me is they wish they had known about it sooner or they wish they had started in it sooner, because they're so grateful. You know, end of life is a very difficult time, and they really get a lot of care and counseling that's very specialized and appropriate for end of life. I think it's not just the payment policy, but I

think clinicians are notoriously poor at recognizing when end of life is there, and perhaps patients and families.

But in my own field, cardiology, you know, congestive heart failure is often an end-of-life condition, and we know that cardiologists are very poor at recognizing when the end of life has come. And so that's another reason for under-referral to hospice care, and it is well-intentioned but very unfortunate.

I support the Chairman's recommendation.

DR. DEAN: I support the recommendation.

It occurred to me in our last discussion and the question about the appropriateness of LTCHs versus hospice. I understand that later on we're going to have a discussion about shared decisionmaking. It seems to me this is one of the ideal places to try to introduce that.

Because certainly, in my experience -- and it's tied in with the fact patients have to -- the current requirement they give up conventional care. And maybe it's just that those of us, as clinicians, don't understand this well enough to explain it or we don't take the time or whatever. But that frightens so many people into rejecting something that clearly has tremendous benefit, as Bill said.

You know, there was at least one study a year or two ago that said that patients that elect hospice live longer than people that go into conventional care.

So I think that this is really an area that has a tremendous opportunity for better definition of what the mechanisms or the process is to present this alternative because it has great value in many ways and it clearly isn't being used ideally. We don't always get the right -- and I think we also need to look at this criteria, this six month projected life span. Because, as Rita said, we're terrible at that. And it seems to me there's probably better criteria.

I mean, you're asking -- for those patients that do enter with diagnoses that we have some questions as to whether they're really appropriate, what was it that triggered the decision to move to hospice at this time? Is this patient really stable? If they're totally stable and have COPD, is that really an appropriate referral? Or is there some sign that, in fact, things are beginning to deteriorate? And is there a way that we could measure or document -- I mean, I don't know. I'm just brainstorming.

But it just seems that we need some better

criteria.

MR. HACKBARTH: My recollection of the history, Kim, and correct me if I'm wrong, is that both the six month requirement and the requirement that the patient forsake care aimed at recovery were driven, at least in part, by a concern that without those constraints hospice could become a de fact long-term care benefit in the Medicare program.

Now we've had other developments recently and litigation that also raise some of those same questions. I'm referring to the case about the improvement requirement.

I wonder to what extent this whole area requires some rethink. I know that under PPACA there was a demonstration established to look at the issue of removing the requirement that the patient forego recuperative care.

Remind me, Kim, that's in the process of being set up now?

DR. DEAN: Isn't there a demo or something that's going on?

MS. NEUMAN: It is in PPACA. There were no funds appropriated, and so it's unclear what will happen.

MR. HACKBARTH: Okay.

DR. DEAN: But some of the private payers, I

think, are doing it; right?

MR. HACKBARTH: Yes, but there's been some questions about whether the private population is meaningfully different from the Medicare population on these issues, whether the same results would apply.

Okay, lots of things, moving parts, in this area that we need to think about how they integrate.

Cori.

MS. UCCELLO: I am supportive of the recommendation. And I'm also interested in learning more about whether or not the distribution of the payments is appropriate. There's some evidence that payments to nursing homes or for hospice care and nursing homes can be different, maybe lower.

There are also program integrity concerns with nursing home hospice, I think.

As well as I'm just wondering if services provided to non-cancer patients are different from those of cancer patients. You read about different kinds of outcomes with those two groups, and so trying to think through that would be helpful.

MR. KUHN: Kim, two quick questions.

First, the issue of the cap. Talk a little bit more about the nature of those hospice that are hitting the cap. Are they geographically in certain states? Are they more kind of long-term care based? Just a little bit more about those.

MS. NEUMAN: Sure. The hospices that are hitting the cap are -- the vast majority are for-profit. They tend to be smaller, on average, in terms of their patient load. They are geographically concentrated in certain States, so places like Oklahoma, Mississippi. There's four or five States that have much higher rates than other places. They don't tend to be overly focused on nursing homes.

MR. KUHN: And on their characteristics, do they tend to take a certain type of patient with a diagnosis? I mean, do they have, like, more cancer patients than others?

MS. NEUMAN: They would have more non-cancer patients than others, but we see a longer length of stay across every diagnosis for these hospices.

MR. KUHN: Okay. Thank you. And I support the recommendation.

DR. CHERNEW: I also support the recommendation and would say that -- you know, Peter talked about IRFs and

LTCHs as exhibits one and two, and I think the rest of these are sort of exhibits three, four, and five to the notion that we have this tendency to segment the system away from where -- what the patient is. Then within each of the segments, we try and set up payment rules. And then we realize that there are problems within those segment rules because we can't deal with the seams between any given system and a bunch of other systems. Then we put in a bunch of regulations. Then the regulations can never be exactly right for a whole bunch of reasons. So we're torn to try and get more information to perhaps regulate better, which we can never seem to do. And there's a huge amount of heterogeneity across all of these, as well.

I've had several relatives in hospice and I have to say, the hospice providers in the cases I had were angels in a whole number of ways. I can't even speak highly enough about them. But that doesn't mean that every provider is that way.

And so I guess, although I support the recommendation, in the end, our solution can't be to segment payment more, figure out more specific services, figure out how to figure out exactly who gets those services, at which

rates, and when, and then regulate. I think the solution at some point has to be to find some patient-centered way of thinking about the system and then making sure that people get the services they need without having to come across these barriers of whether you're a Level 4 hospice or Level 1 hospice, and if you're Level 1, you have to move, and if you're Level 4, you can stay, and -- it can get to the point of craziness, if not worse.

And so although I support the recommendation, I'm really thrilled at the conversation we had today, which I think seemed to have a theme of "there has to be a better way."

MR. HACKBARTH: Yeah. So, I was going to say this at the end, but I'll say it now since Mike lunged.

[Laughter.]

MR. HACKBARTH: I didn't mean that the way it came out.

DR. CHERNEW: No, no, that's fine. I was trying to talk as fast as Kate did.

[Laughter.]

MR. HACKBARTH: So, I agree with everything that Mike just said. Now, fast forward to the spring.

DR. CHERNEW: I'm sorry, Kim.

MR. HACKBARTH: We will be looking at the issue of bundling around hospital admissions. Every time that we've taken that issue up in the past, as people start to dig into it, they say, oh, heavens, this is difficult. This is complicated. And we tend to back away from it.

You know, we face a really -- and I mean, "we," the Medicare program, the broader, the big "we" -- a choice here. This path that we're on -- I'm with Mike. I think the silos and all of the things that he said are true and I don't think this is the way out. I think we need to go to broader bundles of payment, but we shouldn't have any illusions about that being easy, either analytically or politically.

So I just want to prep people for when we come back to bundling. I want everybody to read the transcript from this morning before they come to the meeting and be all psyched up, ready to go.

Peter.

MR. BUTLER: How do I follow that? So, I support the recommendation. I also like the fact that the chapter has right at the beginning said, okay, dummies, we made a

bunch of recommendations before that were pretty thoughtful. Let's restate them and have them prominent.

I think we have an opportunity in this area to educate a lot more maybe than in other areas. And while you had length of stay by diagnosis, in the past, you know, we've had some charts that show the trends and who is a hospice patient and it's rather dramatic to learn that neurological diseases are on such a growth and that cancer is less than half of hospice. But I imagine the general public still doesn't have any appreciation for the full role of hospice and palliative care. So trends and who makes up the hospice population is, I think, important.

Not the least of which is that -- and this is where, I think, hospice is a little different kind of silo. As much as I'm into bundling, this is the one tool that helps ease end of life in a graceful way. And so one of the reasons for the disease mention is that Alzheimer's is overwhelming us, and a lot of the neurologic growth, I think, in hospice care is in that area. And if we can learn more about what role hospice actually plays in a disease like that that doesn't have this predictable six-month time frame to it, we might even end up with some kind of revised

approach towards a huge disease that is a little different than maybe the benefit is structured today.

DR. BAICKER: And here I was to take up Mike's challenge to talk even more quickly.

[Laughter.]

DR. BAICKER: So, I'm supportive of the recommendation. Hospice, unlike most of the other things we look at, we're actively worried about lengths of stay that are too short and people not taking full advantage of something that would be of great benefit to them.

So, I'm also supportive of the recommendation to explore ways to make the benefit more flexible, and I'm taking the caveat that the private sector results may not generalize to what we see here. I think this is an opportunity to explore some of those alternatives, like eliminating the requirement to forego curative care, as well, that might really benefit beneficiaries and not increase program costs.

And, of course, there's a great deal of uncertainty about what the optimal length of time is. There is inherently a lot of uncertainty about how long patients are going to be in hospice, and so we have to take all of

those lengths of stay with some nuance. But, I think, promoting greater utilization of the benefit would be in everyone's best interest.

DR. NERENZ: I'm generally supportive of the recommendation, supportive of the concept of hospice and make sure we want to do things that support its growth, and also supportive of the comments about trying to move away from the silos, okay, all that said.

If we could go to Slide 15, please. I'm just struck here again by the striking difference in margins between the hospital-based and the freestanding, and it just echoes something that we have seen now several times. We saw it in the IRFs and I'm even seeing -- back yesterday morning, we were talking about the inpatient and outpatient margins for hospitals, which are seeing negative, negative, negative. And I suppose, in principle, you'd say, well, hospital managers are just bad managers, but I don't think that is true.

There's something else going on here -- no, I just -- I want to set that aside. I don't think that's true. But there's something else going on here, and I suspect it has something to do with certain underlying costs that are

either built in as a part of program regulation or they have something to do with broader missions that hospitals serve in the community.

On page 34 and 35 in the report, you did some analysis of what some of those costs might be here, and I don't want to explore that in detail. Just making the general point, it would be very useful to me to understand if there are, indeed, some essential underlying costs that relate to hospital that find their way into a whole bunch of these different silos, I would very much like to know, do those costs truly add value to patients and families and communities, because I think then we would think about payment adequacy in one way. Or, do they not, and then we would think about payment adequacy in another way. It comes up here, but it just comes up other places, as well.

MR. HACKBARTH: Other people, feel free to jump in and correct me if what I say is incorrect.

I think that, actually, the answer may vary across the different types of care. In the case of hospice and home health, you're talking about services that ordinarily don't have a big capital infrastructure, bit management structures, and so the allocation of hospital institutional

overhead to those types of providers may really make them look like their costs are dramatically higher.

When you're talking about an IRF or an LTCH, which has a much more similar sort of structure to a hospital, including some of the regulatory requirements, then there might be other reasons, patients difference reasons, et cetera, for why hospitals perform -- hospital-based perform less well. But I think you do need to take into account that some of the services, it could be driven strictly by the allocation of hospital overhead.

DR. NERENZ: Agree, absolutely, although I just would observe in that case, then if hospitals didn't allocate that way, then the margins that we'd see in the other services would be even more negative than they currently are.

MR. HACKBARTH: Although you'll recall when we look at the hospital margin, we look at the overall margin and not product line. So it is all --

DR. NERENZ: [Off microphone.] Understood.

DR. SAMITT: So, I would support the recommendation. In fact, I would predict that we will likely want to be more generous in future years. That

perspective comes from, I guess, an organization that is living in the world of the Accountable Care Organization. You can bet that I will not back away from the notion of the importance of bundles. I believe in them, and I'm worried that, actually, as we talk about each of these distinct silos, that Medicare is shouldering a burden that from my point of view should be shouldered by the providers.

And so to give you a kind of a sense of the way that we think about hospice in our world is we measure four things. We measure to what degree are patients aware of their options, and are we doing a good job educating patients about end-of-life care and the options that they have?

Second, what are the rates of terminally ill patients that are dying in intensive care units or in LTCHs when it doesn't feel humane that that is the way the beneficiaries die?

Third is what is our hospice length of stay? Do we have too short of a hospice length of stay to suggest that we're not referring soon enough to hospice? And, likewise, do we have too long of a hospice length of stay to suggest that perhaps hospice wasn't the right choice when we

make a recommendation?

So I believe that the providers really very much own this responsibility, and while we're thinking of payment methodologies to focus on hospices that are too short and too long, I think in the world of accountable care and in the world of bundles, providers very much step in and take some accountability for that, which is what I think is lacking.

MR. GEORGE MILLER: I was very encouraged to hear the physicians' very strong support of the hospice concept. In my own personal experience, the physicians who are hospice physicians just have an incredible understanding of end-of-life care and what should be used and what shouldn't be. I think this is, to echo what the other clinicians around the table have said, this is an area of service that is a huge benefit to the Medicare beneficiaries and also a way to save my gazillions of dollars to the program in an effective and meaningful way. Notwithstanding what Craig said about bundled payments, and I think it can be included in the bundled payments. The difficulty would be is making a decision about what shouldn't be there and what we shouldn't pay and in lieu of the hospice benefit.

Again, personal experience and folks who are dealing with end-of-life care, where we direct patients to the hospice. It saves the program a lot of money. It is better for the patients. And understanding the inevitable outcome that some folks are going to die, it is a humane thing to do.

So I support the Chairman's draft recommendations and look forward to discussion as we really tackle this issue in the future.

MR. HACKBARTH: We finished seven minutes ahead of schedule. Anything more you want to say, Kim?

[Laughter.]

DR. CHERNEW: Say the same thing slower.

MR. HACKBARTH: Right. Okay. Thank you very much.

And we'll now have our public comment period. Kim, you'll put up the ground rules.

I know you're familiar with the ground rules --

MR. KALMAN: I am, and I'll be brief, also.

MR. HACKBARTH: So when the light comes back on, that's the end of your time.

MR. KALMAN: Okay. My name is Ed Kalman and I'm

with the National Association of Long-Term Care Hospitals. I'd like to make three observations.

First, with respect to the payment efficiency of cases that go to long-term care hospitals versus cases that stay in acute hospitals, whether it's an ICU or a step-down unit, we did a study a year or more ago where we regrouped all the cases and asked what would Medicare have paid if they stayed in the acute hospitals, and one of the findings that came out of that study, there was a whole bunch of cases where Medicaid [sic] paid less, and the reason was, as you've noted, a lot of these cases would be cost outliers in acute hospitals. Cost in acute hospitals that Medicare pays is overhead for ICUs, operating room, GME, IME, none of which exist in a long-term care hospital. So a long-term care hospital is much more payment efficient for a segment of cases that are chronically critically ill.

Secondly, we are very concerned about the 400 percent difference in cost outlier patients between low-margin and high-margin outliers, and that defines for-profit versus not-for-profit, which is critical. And we believe that there is a difference. There is a patient characteristic difference, whether it be fragility of

illness or whether it be payment source and difficulty in placement, particularly cross-overs and the medically indigent.

I think it would be a good idea when you study this issue to take a look at readmissions for higher-margin and low-margin providers, and what you will find is since the long-term care hospitals are keeping them longer, and since RTI found that long-term care hospitals have better readmissions, at least for 30 days out on a case-mix adjusted basis, is that Medicare is also saving money for -- with these low-margin LTCHs that serve these cases because they're keeping them and they're not being readmitted to acute hospitals. And they're also probably not going to the SNFs that won't take them because of some payment issues and avoiding those high rates of readmissions. So we think you ought to look at that.

Thirdly -- I think we're doing quite well on speed, by the way -- we would like to invite your attention to the fact that CMS is supposed to have an eight percent outlier pool for long-term care hospitals. That is eight percent of all the payments are supposed to go to the outlier cases, which establishes a threshold. CMS has been

remarkably inaccurate. Last year, it was supposed to be eight percent, but CMS actually spent six percent. That is a 25 percent error rate, which exists every year. So these hospitals that have very low margins and are probably saving the Medicare program money because they're holding the cases, they're not going, they're preventing the readmissions, they're being paid less for the outlier patients than they should. And that is something that the Commission should look at in terms of whether it's a valid issue and maybe suggest that there be a positive adjustment to account for years of underpayment for cost outlier cases.

Finally, just a simple observation on your allocation question that you've asked. The Medicare cost report forces it. If there's a hospital-based provider, like a SNF or a hospice, then the Medicare cost report automatically puts all that high overhead to that square footage. So that's why you're seeing the numbers you see.

Thank you.

MS. SHEEHAN: Kathleen Sheehan with the VNAA, and I'll be very quick. We'll follow up with a letter.

I just wanted to comment today on the discussion that took place regarding looking at are we creating -- or

are we looking at a system where we have a group of very efficient for-profit provider delivery systems that are making the high margins, and then you attempt to cut them and then the nonprofit delivery system suffers, and it's similar to the comments that were just made.

The nonprofits are certainly taking the most difficult patients. They're also taking patients that are rejected by other providers, where there's extensive travel, particularly in rural communities. But they're taking the more difficult, the more challenging patients. Our members tell us that they actually receive patients that come in the hospital. They have basically one or two days of care and they're gone. And they even have patients that really die within the hour of when they receive them.

So they're very concerned about States where there is no Certificate of Need process and there's really rampant competition and much of the things that I think the OIG is looking into related to marketing. I think that many physicians, perhaps, are not aware of some of the requirements that need to be met in terms of placing a patient and are very susceptible to marketing techniques.

And so we've urged CMS, and I know that you all

have, to look very closely at a moratorium, to be constantly aware of the distinctions with the nonprofits, and to pay particular attention to rural communities, which I think are really struggling in terms of trying to serve patients with hospice care, and home health, as well.

MS. ZOLLAR: My name is Carolyn Zollar. I'm with the American Medical Rehab Providers Association, representing the rehabilitation hospitals and units, and I just had a couple of comments.

There was a tremendous amount of data discussed during the session on the IRFs and we have some concerns about some of it. We may get back to you.

Just to highlight that with respect to the comments on the care tool, everybody had looked forward, very eager to see the apples-to-apples comparison, but that data was 2008 and we're now in 2012 and that there have been some shifts in our IRF data that is not captured by that same tool. So we do see some changes in the acuity of the patients increasing over those four years and increasing change, you know, seeing in their comorbidities as they come. So there may be some changes, that if you're looking only at the care tool, that are not captured now.

On the definitions of readmissions, we're spending some time looking at that, too, and I could not tell from the data that was presented, because a lot of the policy discussion is, should there be planned readmissions included in these definitions or not, because frequently in our small world, a patient will have a planned readmission. And if it's lumped into the larger statistic, then it might be deceiving, whereas if it's pulled out, as the Yale studies, which is the basis of the CMS work on readmissions, then the numbers look a little bit different. So I'd mention that.

And also, in the area of bundling, we have a proposal for post-institutional rehabilitation and medically complex care, which we've mentioned before, the continuing care hospital, and I'd like to happily mention it again, when you move to your discussions of bundling for post-acute care.

Thank you.

MR. HACKBARTH: Okay. Thank you.

We're adjourned until January.

[Whereupon, at 11:46 a.m., the meeting was adjourned.]