MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Welcome to our guests in the audience. We have two parts to our meeting today. The morning session is going to be devoted to finalizing recommendations on three topics. And then this afternoon we will begin our annual review of the data informing our update recommendations. We'll also look at draft recommendations on updates, although the final votes on updates will occur in January.

So the first topic for this morning is increasing participation in low-income programs. Joan?

DR. SOKOLOVSKY: Good morning. As we have discussed over the last few months, Congress has established a number of programs to provide financial assistance to Medicare beneficiaries with limited incomes. Although programs like the Medicare Savings Programs provide significant savings, that majority of eligible beneficiaries do not participate. Today we will briefly review the results of our study on how to increase participation in these programs.

Last month, Bob, you asked a number of questions about some of the data on beneficiary income and spending.

And Jack, you asked about how state contracts with SSA are structured. We have tried to respond to these questions in your reading materials and will be glad to discuss them further on question.

This morning we'll present three draft recommendations for your consideration that are designed to increase participation in these programs. We will also present some of the issues involved in federalizing the MSP programs.

In the course of our research, we found that Medicare beneficiaries typically have lower incomes and higher out-of-pocket health care spending than the rest of the population. The majority of eligible beneficiaries do not participate in programs like MSP and LIS that are designed to assist them with some of their out-of-pocket costs. In the past decade, the Federal government, the states, and local community groups have tried to increase participation and have achieved limited success. Targeted outreach and administrative simplification have been the most effective strategies.

The Federal government provides funds for Medicare beneficiary education and counseling through the National

Medicare Education Program. State Health Insurance Assistance Programs, also known as SHIPs, are one component of this program. SHIPs are state-based organizations that provide information and personal counseling for Medicare beneficiaries. They are the only part of the Federal education program that provides one-on-one counseling to beneficiaries. SHIPs receive about $30 million annually from this program, down from almost $33 million in 2005. The current funding limits their ability to do more targeted outreach to low-income beneficiaries.

So draft recommendation one reads: The Secretary should increase SHIP funding for outreach to low-income Medicare beneficiaries.

Increased funding for SHIPs and other groups that provide expertise and individual counseling will permit more beneficiaries to learn about and apply for programs for which they are eligible.

The spending implications here are indeterminate. Program spending would increase based on increased participation in MSP. Beneficiaries with limited incomes who enroll in MSP or LIS would save money.

More targeted outreach, as called for in draft

recommendation one, while helpful, is likely to have only a limited effect on participation rates if the application process is too complicated and documentation requirements are too onerous. State eligibility and application and retention procedures have a big effect on how simple or difficult it is for beneficiaries -- and those helping them -- apply for MSP.

Although the MSP asset level has not changed since 1989 when QMB was first established, states have a lot of flexibility in using this criteria. Some states have used this flexibility to effectively raise MSP income or asset benefits. For example, a number of states have disregarded all assets.

When the Congress set the income and asset limits for LIS in the MMA, it set them at a higher level than MSP, recognizing that people with incomes below 150 percent of poverty could have difficulty paying their out-of-pocket health care costs. If Congress raised the income and asset level in MSP to coincide with LIS, alignment with LIS would make it possible to use one eligibility determination and enrollment process for both programs.

So that leads to draft recommendation two: The

Congress should raise MSP income and asset criteria to conform to LIS criteria.

Under this recommendation, beneficiaries with incomes of up to 150 percent of poverty would be eligible for QI benefits. Just to be clear, the income limits would only be raised for QIs. The asset limit rises about $3,500 for QMBs and SLIMBs and somewhat more for QIs.

If income and asset levels were the same for both MSP and LIS, beneficiaries could be screened and enrolled in both programs simultaneously. Beneficiaries would find the process simpler and the government would realize administrative savings.

This recommendation should increase participation in MSP. We estimate that this recommendation could increase program spending between $250 million and $750 million for one year and between $1 billion and $5 billion over five years.

Much of this increased spending is driven by the cost of continuing the QI program. Recall that this is a block grant that Congress must reauthorize. It's not likely that it would, in fact, continue to fund this program even without this recommendation. And each year that it's

extended, QI is estimated to cost about $300 million.

Low income beneficiaries who rule in MSP under this recommendation would save money.

The Social Security Administration is responsible for determining eligibility for the low-income subsidy for those individuals who are not deemed eligible because they are in Medicaid or one of these MSP programs.

Beneficiaries can apply for LIS without facing the possible stigma associated with applying for help at a state Medicaid office. Under the law, beneficiaries who apply for LIS at a state Medicaid office must be screened for other programs like MSP that they could be entitled to. SSA does not have this responsibility. However, currently more than 30 states contract with SSA to determine Medicaid eligibility for SSI beneficiaries. Thus, the Agency has the expertise to conduct eligibility determinations.

If MSP and LIS eligibility were based on the same criteria, SSA could screen and enroll beneficiaries for both programs at the same time, although they would clearly need more resources to do so.

This leads to draft recommendation three: the Congress should change program requirements so that SSA

screens LIS applicants for Federal MSP eligibility and enrolls them if they qualify.

This recommendation would simplify application and enrollment for beneficiaries and counselors. SSA could use one application for both programs. It would increase participation in MSP for beneficiaries who have heard of the drug subsidy. It is unlikely to increase enrollment by beneficiaries who do not already know about the drug subsidy. If MSP and LIS criteria were the same, it would limit the increased SSA workload although, again, they would need additional resources to do this.

CBO has not produced a separate estimate for this recommendation. We believe that the cost is largely included within recommendation two. This recommendation would increase participation in MSP. To the extent that participation increased, it would increase program spending. Beneficiaries again with limited income who enroll in MSP would save money.

The draft recommendations presented here mostly affect Federal spending. Income eligibility for QMBs and SLIMBs would remain the same and the increased income limit of 150 percent of poverty only affects the fully Federal QI

program. The asset limit for QMBs and SLIMBs is increased somewhat but the asset limits for QIs would be raised much more.

Some Commissioners have asked whether the change in the asset limit would disproportionately affect some states. We're talking about a single national policy but because states have different populations and different eligibility and payment standards, these recommendations may have a different effect on different states. This isn't something that can be easily quantified. Some factors we would need to take into account, for example there are already different current take-up rates within states, different state eligibility levels -- again as I mentioned before, some states have completely erased the asset test or have set it at a higher level than the LIS standard. Some states have larger Medicare populations and larger populations of beneficiaries with limited incomes. The Federal government currently pays more than half the cost of QMB and SLIMB benefits but the Federal match rate among states also varies considerably from about 76 percent to 50 percent.

Finally, data to answer many of these questions

are old and unreliable.

Last month, Bill addressed the possibility of federalizing all the MSP programs since MSP applies to Medicare beneficiaries and covers Medicare benefits. So we looked into some of the questions we would need to consider in order to make them fully Federal programs.

Unlike the draft recommendations that focus on how to increase participation in the current programs, federalizing MSP mostly involves Medicare buying out the cost of a benefit currently paid by Medicaid. Since states have different eligibility and payment rates, a single Federal standard would lead to winners and losers. In other words, some states gain and some lose, and some beneficiaries within states gain and some lose. So as I go through some of the design questions that you would have to take into account, you might want to think about how each decision would affect who wins and who loses.

The first question, which of the eligibility groups who received MSP benefits would be affected by federalizing? In our work, we focused on people who are only eligible for MSP benefits but well over 80 percent of the individuals that received MSP received full Medicaid

benefits, including access for example to long-term care services. About one-third of states provide full Medicaid benefits to beneficiaries with incomes below 100 percent of poverty. Equity issues among states would be raised if federalization applied only to beneficiaries who received MSP-only benefits.

The second question, would eligibility be governed by a national standard or a higher level that's chosen by the state? Some states, as I've mentioned, disregard higher levels of beneficiary income and assets than the limits even in draft recommendation two. If federalization applied to all beneficiaries currently enrolled, eligibility would continue to vary by state. If only the national standard applied, beneficiaries who currently received MSP benefits would lose benefits or states would have to cover them using state-only money.

Currently, states can limit cost-sharing payments for Medicare covered services to the lesser of the difference between the Medicare payment and the maximum the state would have paid for the same service under Medicaid. The majority of states do not pay the full Medicare coinsurance for all services. If MSP was federalized,

Medicare could pay the full cost sharing for the services, an amount which would further increase the cost of federalization, or pay some percentage of it.

In order to estimate the cost of federalizing MSP benefits within the context of the three draft recommendations, we assumed that federalization would include all QMBs and MSP people and that Medicare would pay full cost-sharing. Under these assumptions, we estimate the cost of MSP federalization would be greater than $2 billion for one year and greater than $10 billion for five years.

The costs could be reduced if states were required to maintain their current level of effort. This could again raise equity issues if states that provided more generous benefits were required to continue to pay more for a Federal benefit than those who provided less generous benefits or covered fewer eligible beneficiaries.

We look forward to your discussion.

MR. HACKBARTH: Nice work, Joan and Hannah, on this project. Let me start with a couple of comments, one about the context, for those in the audience who haven't followed this discussion over the last several months.

One of the reasons that we initially took this on

was that the issue of support for low-income beneficiaries became an issue in the discussion about Medicare Advantage. One of the arguments made on behalf of the current level of payments is that the money is being put to good use and one of those good uses is to provide added coverage for low-income beneficiaries.

So accepting that that's a reasonable policy goal, we said well, how else might that be accomplished if not through Medicare Advantage? Of course, there are the existing vehicles of the Medicare Savings Program. But alas, they have limitations, limitations both of design and effect and whether they reach all of the population. So that was how we got into this.

Which leads me to talk about the budget impact. Here I'm speaking just for myself, obviously not for the Commission. What I would prefer is that we reduce Medicare Advantage payments and redirect a piece of that money towards better low-income support and will achieve the goal at much lower cost to the Federal budget. And so there would be no net increase. There would be a net reduction in Medicare payments. But that's just my view.

Would you put up recommendation two for a second,

Hannah?

Assuming that there isn't a Medicare Advantage offset, we're saying that there's an incremental Federal expense associated with this approach. I just want to get a clarification. I think you said, Joan, during your presentation, that a piece of this incremental cost is, in a sense, an artifact of the baseline rules. The QI program, being an annually appropriated program, is assumed under the baseline to go away each year. And so if you assume that it's extended that, in and of itself, has an increment cost; is that right?

DR. SOKOLOVSKY: Yes. And in fact that, in and of itself, puts us in this bucket.

MR. HACKBARTH: So the single largest piece of this incremental cost is due to this artifact of the budget rules; is that right?

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: I just thought it was important for people to understand why that number exists.

Okay, other questions or comments about the recommendations? Bob.

DR. REISCHAUER: I might have misheard you, Joan,

but I thought you said that the QI program cost $350 million?

DR. SOKOLOVSKY: They estimate $300 million a year.

DR. REISCHAUER: Then how do you get the $250 million?

DR. SOKOLOVSKY: That's our bucket.

DR. REISCHAUER: Oh, just the size of the bucket. Okay.

MS. HANSEN: One of the things that we had a chance to do a little bit earlier is speak about the program's incrementalist approach, as compared to looking at the issue initially brought up in the last meeting that you addressed by Bill about the federalization approach. I was one of the ones that was quite taken with the thinking that Bill had offered about federalization, but I understand that between the MA issue, wishing ideally that the funds that could be saved from the reduction of the MA plan's extra payments to this needs to be considered in the budget component of it. So I do appreciate the incremental approach here.

But one of the things I wanted to acknowledge,

which I really support, is the third recommendation that the Social Security system perhaps be a venue for this. One of the things I have learned since the last meeting that just concerns me, even though we acknowledge that Social Security -- in our notes -- require more resources, I was quite taken by the fact that apparently the Social Security system that has gradually been losing proportionate funding to its growth, that its current staffing levels is that of the staffing level of 1972. And that staffing level is actually dealing with double the number of beneficiaries that they dealt with in 1972.

So I think the ability for us to -- and I am probably one of the first people to make sure that the beneficiary has a very dignified way of accessing benefits -- the infrastructure of Social Security is quite tenuous. In fact, I understand there are closures of Social Security offices.

So as we think about doing this, our ability to perhaps support the point of the infrastructure of Social Security might be built up a little bit more in the text of the paragraph just so that we can be fair.

I almost recall this as a comment that we might

make of CMS sometimes when we request of them to have data. But Social Security itself is going through quite a bit of a challenge right now.

Thank you.

MS. BEHROOZI: Thanks very much. I just wanted to bring out a point that you make in the paper, Joan, which is that cost barriers faced by low-income beneficiaries may force them to avoid necessary health care. And so I think it's worth emphasizing in all of the recommendations the implications to the beneficiary is expressed as low-income beneficiaries will save money. But they can only save money if they were going to access the care.

So I think it's really worth emphasizing that they will not avoid necessary health care due to cost.

DR. REISCHAUER: But isn't it true for many of these people what we're talking about is paying the premium, the Part B premium, which -- well, but they're all enrolled already.

MS. BEHROOZI: Right but isn't it also cost sharing? Okay.

MR. EBELER: Also, I think it's a good set of recommendations. Thank you for the good work.

The issue of federalization is one that the questions you flagged sort of raised the complexity of that and it seems as though it's best to take that question up separately in the context of how one rethinks benefit design in Medicare, which I know is a longer-term project that the staff is looking at, which includes questions of how better to make sure that the lowest income can actually afford the structure of cost sharing that is in place for the rest of the Medicare beneficiaries, as well as other issues of benefit coverage such as catastrophic.

So it just strikes me that moving with these recommendations now makes a great deal of sense. And then looking at those broader issues in a more comprehensive context would be the best way to go.

DR. SCANLON: I would echo what Jack is saying. I think you've done an excellent job in terms of starting to display the complexity of this issue. I think we come to this, in part the context that Glenn gave, in trying to think about how, outside of Medicare Advantage, can we protect people with lower incomes. I'm in concurrence with Glenn in terms of how we should be paying Medicare Advantage plans so that there is a potential that we would have

funding for alternatives.

With these MSP programs, we've had for many years, a great sense of disappointment in terms of how well they've worked. Part of it is the fact that they are jointly tied to the Medicaid program. And you highlighted, in many instances, how variable Medicaid is across the country. And that creates issues of equity in both directions. This question of some people would be better off if we federalized something and others are going to be worse off. We have to think about what the balance is there that we want to achieve.

This whole idea that Medicaid doesn't necessarily pay the Medicare cost sharing in full raises whole questions about access. How are access for Medicaid/Medicare dual eligibles, how is it compared to access for someone who is Medicare only and able to pay the cost-sharing?

So I think this is a very complicated question that needs to be explored more and I'm glad to know that we are going to be looking at this bigger question of the Medicare benefit package and think this is a part of it.

For the short term, there has been this really strong feeling that if we did a better job with outreach

that we would do better in terms of participation in MSP. And certainly using the Social Security offices -- let's hope that they've used IT to make up for some of the reduced capacity in terms of staff -- that using the Social Security offices, using the SHIPs more, is a step in the right direction.

The other thing in terms of rationalizing income and asset level so that we deal -- we maybe should start thinking about Part D as a model, a model in terms of setting a standard, providing some protections beyond Medicaid, providing for catastrophic protection. Those are the kinds of things that we've talked about for a long time in Medicare, and that it's potentially time to think about how do we apply those to A and B, as well?

Not to suggest that this is all about program expansion, there's another element of Part D which people may think about as a model, or at least a part of the MMA, which is the fact that we introduced higher Part B premiums for higher income people. MMA changed dramatically the Medicare model and it's worth thinking about this in a broader context.

MR. HACKBARTH: Other questions, comments?

DR. STUART: I'd like to raise the issue that you raised, Glenn, which is the relationship between MA overpayment and this issue. The MA plans have made the case that, in fact, they are enrolling significant numbers of low-income beneficiaries and are providing some of these services, in terms of paying for the pain coinsurance and the like already.

And so my question to Joan is whether there are any estimates of the amount of benefit that is going to low-income beneficiaries in MA plans that could be offset, in a sense, by the recommendation here if we had federalized this program?

In other words, if these services were, in fact, being covered now by the overpayment then if you recoup that then your actual costs would go down. But it depends upon how much of those services are actually being provided now.

DR. SOKOLOVSKY: This is a good question but a question that I am not qualified to answer. Our MA people would be much more -- I don't know if they can answer it.

DR. MILLER: I'm looking at Carlos and Scott. My sense is that this issue has kind of come up when we were churning through some of the MA discussions. And exactly

which benefits are being delivered by which plans and used by which beneficiaries is something that we can't get at. I think we can get at rough estimates of how proportions of the enrollment are below certain income levels. I think we do know that -- if I could get the nod out of somebody over there. Right. So I think we can give you that.

But the notion of then how much is actually used, I think that we can't quantify. If I could get one more nod? Right.

MR. HACKBARTH: Okay, are we ready to move ahead with our votes? Would you put the recommendation one? All opposed to recommendation one? All in favor? Abstentions?

Number two: opposed? In favor? Abstentions?

Number three: opposed? In favor? Abstentions?

Okay, well done. Thank you very much.

Next we will consider the recommendation on Part D data availability. Rachel.

DR. SCHMIDT: Good morning.

Last month we had a detailed discussion about Part D and several of you had specific questions. I will try to answer some of them as we go through the material today but if I don't get to all of them please know that I haven't

forgotten you and I will get in touch with you off-line with those specific answers.

And the computer magically changed sides for me so there we are.

Today our time is limited so I want to focus your attention on a couple of specific issues from last time. They're highlighted at the bottom of this slide. The fact that larger number of beneficiaries who are receiving Part D's low-income subsidies are being reassigned to a new plan for 2008 and the draft recommendation that we discussed last time that would provide MedPAC and other Congressional support agencies and selected Executive Branch agencies with access to Part D claims information.

More than 9 million Part D enrollees receive low-income subsidies, which pay for most or all of their premiums and cost-sharing. Not all plans qualify as premium free to these beneficiaries. Plans have to have a premium at or below threshold values that CMS sets annually for each region based on plan bids. This chart is showing you that for 2008 most regions have more than 10 PDPs that qualify -- that's the medium and dark green areas -- and the least number available in the region is fine. The average low-

income subsidy enrollee has about 14 qualifying PDPs to choose from.

The annual process of setting these regional thresholds was designed to give plans incentives to control growth in drug spending and to bid competitively. If a plan's premium is below the threshold, it gets to keep its low-income subsidy enrollees for the year unless those individuals choose to leave the plan. But if it's premiums is above the threshold either the beneficiary has to decide to pay part of the premium to stay in the plan, or they pick a new qualifying plan, or CMS reassigns those individuals to a new qualifying plan.

So one outcome of Part D's competitive bidding system is that there is turnover among the plans that qualify from year-to-year, which means that some beneficiaries are going to be affected.

At the same time, remember that beneficiaries who do not receive low-income subsidies are affected by premium changes, too. I told you last that premiums are going for 2008 and one estimates suggests that nearly 20 percent of current PDP enrollees could face a premium increase of more than $10 per month if they remain in the same plan. Some

beneficiaries who pay the entire premium on their own will decide that they need to switch plans in order to keep their drug benefits affordable.

For any beneficiary who switches plans, this almost always means they must change formularies. That can affect the specific drugs available to them, the pharmacies that they can use, the degree to which they have to navigate utilization management requirements, and the processes that they have to go through to get exceptions and appeals. In turn, these factors can affect their adherence to drug therapies as well as provider costs for helping them switch formularies and perhaps get exceptions.

For 2008 there are 2.6 million low-income subsidies enrollees in plans with premiums that are now above the threshold. CMS is reassigning 2.1 one million of these beneficiaries to new plans unless they choose to stay where they are and pay part of the premium. Another 400,000 need to pick a new qualifying plan on their own. CMS may reassign up to 1.2 million of the 2.1 million to a new plan with a different sponsor and a different formulary.

Last time you asked how many of these are long-term care residents. CMS tells me that of the 2.1 million

that are being reassigned, 231,000 are full dual long term care residents and a little under half of those individuals are being reassigned to a plan with a different sponsor.

We've talked about the fact that for 2007 CMS did not follow the law and did not weight plan premiums by enrollment when it set the regional thresholds. Last year this artificially kept down the numbers of beneficiaries that CMS needed to reassign. About 1.2 million beneficiaries were affected but only about 250,000 were reassigned to a plan offered by a different sponsor, so again a different formulary. CMS used its demonstration authority to phase-in enrollment weighting, which raised Medicare spending by about $1 billion last year. This led the Commission to reiterate its position that CMS shouldn't use general demonstration authority simply to increase payments.

Now for 2008, CMS is using enrollment weighting to a greater degree than it did in 2007 but we're still not at full enrollment weight. I've heard this likened to pulling off a Band-Aid slowly, rather than ripping it off.

Last time you asked me if there was a time frame for getting to full enrollment weighting and I put your

question to CMS. They said that they haven't yet decided whether to extend the two demonstrations that deal with enrollment weighting.

CMS uses other policies to limit the effects of year-to-year changes in the regional thresholds on beneficiaries. For 2008, the Agency is letting plans with premiums within a dollar of the thresholds remain free to their current LIS enrollees. This is called the de minimis policy. Last year CMS used a value of $2 for its de minimis policy. CMS tells me that about half a million of the 2.1 million beneficiaries that it is reassigning for 2008 would not have needed to be reassigned if the Agency had used a $2 de minimis policy.

CMS also reassigns beneficiaries to a qualifying plan offered by the same sponsor first, if that's available, since sponsors often use the same formulary across plans. And CMS requires all plans to have a transition policy in place for any new enrollees, including those who are being reassigned. These policies are supposed to give the enrollee one temporary refill of their current drugs in order to give them time to go back to their provider and see whether they can change prescriptions to match the new

plan's formulary or seek an exception from the plan.

Right now stakeholders are debating what to do about the fact that CMS is reassigning a larger number of LIS enrollees. The end of the year is upon us so it's not clear that there's not much one can do at this point to change things for 2008. Nevertheless, some of the ideas in the environment include enforcing plans' transition policies better and doing a better job of communicating with beneficiaries about the fact that they need to go back to their physician and get a prescription that's on the new formulary or an exception. At the other end of the range is a topic that came up at our last meeting: having CMS take Medicare Advantage rebate dollars out when it sets the regional thresholds.

The first three ideas on this slide are more administrative in nature. In other words, CMS could probably do these on its own. Each of them would mitigate some of the problems that come up when beneficiaries have to switch to a new plan and a new formulary but they would also raise Medicare spending to some degree. The last two bullets would probably require a change of law. Removing rebate dollars would also raise program spending.

The next to last bullet on this slide -- what I've called beneficiary-centered assignment -- is attractive because it could conceivably benefit that enrollee and lower program spending, depending on how it's carried out. We talked about this idea last spring. It's the notion of matching beneficiaries' past use of medications with plan formularies when they're being reassigned. We'll be back to you this coming spring with a fuller analysis of it.

One thing you raised last month is that the timetable for reaching full enrollment weighting is important because reassignments will probably reach a steadier state at that point. But bear in mind that reassignments of LIS enrollees and the fact that other people who don't receive those subsidies and face premium increases will need to change plans is something that won't go away entirely. Part D uses a system of competitive bidding and the trade-offs in such a system are that while it provides incentives for plans to manage drug spending, it also means that plans that bid less competitively have higher premiums which again affects enrollees. So we might want to think about this issue more generally, how to help all beneficiaries and perhaps especially those who are lower

income ones when they have to switch among plans.

Last month we also talked about how lack of access to Part D claims data is of concern to the Commission. We need drug claims to help us carry out our mandate of advising the Congress on Medicare policy. Despite the fact that we've been spending nearly $50 billion annually on Part D, right now we cannot answer some very fundamental questions about how the program is operating, things like what kind of access beneficiaries are getting to prescription drugs, which drugs they're getting, and how much they're paying out of pocket. Drug claims would allow agencies like the Food and Drug Administration to monitor the safety of new drugs after they enter the market. Claims information would also let other agencies -- even including CMS itself -- better evaluate the program and promote public health.

You know that CMS has a proposed rule pending that would resolve some ambiguities in the law and would allow the Agency to make drug claim information available, subject to appropriate data use agreements. But that rule was proposed over a year ago and does not appear to be moving forward.

Some stakeholders have objected to releasing Part D claims information on the grounds of protecting patient and provider privacy and protecting proprietary information. We believe that CMS could provide access to claims information in such a way that protects privacy where appropriate and preserves the integrity of Part D's bidding process.

Two years ago the Commission supported a recommendation that directed the Secretary to provide Congressional support agencies with Part D claims information. But given that the proposed rule has not moved forward and could be subject to legal challenge, last month you discussed in this draft recommendation which is directed towards the Congress rather than the Secretary. It says the Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to Congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

I look forward to your discussion.

MR. HACKBARTH: Before we turn to the recommendation, any question or comments on the other part

of Rachel's presentation?

DR. DEAN: I would just say I don't whether these changes affect my area right now, but one of the real concerns in rural areas is access to pharmacy services. I think I mentioned this before. And this forcing people to change providers, change plans, that may or may not have a contract with the local pharmacy, could have some really major implications.

In my situation we have a small private pharmacy in my hometown and the next closest one is 50 miles away. Even right now we have some significant problems with access to pharmacy services on weekends and holidays and all of those things when that pharmacy is closed. Fortunately, we have a very cooperative pharmacist who even -- you know, we call him up and he'll come out and open the store if it's something we really need. But I don't think we can depend on that.

In fact, Medicare Part D has significantly diminished their margins on all a whole lot of their business because we have an elderly population. And so the long-term viability of that entity is really seriously in question right now. And if they go out of business, we're

going to have a big area with really no pharmacy services available.

And they contract with most of the Part D plans right now but not with all of them. If we start forcing people to change too often, I think we could have some real problems with access.

MS. HANSEN: I certainly want to concur, Tom, not that I have any of the rural experience. But I was just thinking about this gradual phasing in of how much risk the plans will continue to take, as we have more beneficiaries having to switch this next year, I imagine in 2009 that will be perhaps more. So I look forward to your spring report and think about the kind of -- not only the administration type of things that CMS could do relative to buffeting this kind of whipping around experience that some of the beneficiaries may have to do, but whether or not there's a sense of urgency of anticipating some of these issues so that we can mitigate this kind of switching around.

Because I think it has again such an impact although we have a larger prescription period for people, that kind of change factor for people for whom access is somewhat of a barrier already, it just puts people more at

risk.

I know this is a simplistic thought but on the back end, when people don't take their medications and all, the kind of other expenditures that can come out of that in terms of quality of care issues are there. And I don't know that we can quantify them. But it's just a trajectory that many of us are familiar with.

MS. BEHROOZI: The switching itself is a big problem and I wonder, just thinking back to the last discussion about education of beneficiaries, if we could think about making recommendation about the kinds of education that plans would be required to do about formularies for new enrollees.

Our experience in the fund that I administer, we just went from a formulary that covered 13 drug classes to 39. We made the switch on October 1st. We had at least a six month rollout prior to that with all kinds of education, targeted information to people whose drugs were now going to be on the formulary, general education to everybody, not only copies of the formulary but very targeted information.

We still went from three-quarters of one percent of our members using prescription services who were

unnecessarily paying copayments to 5.5 percent for the first month of this program. So somehow the message still hadn't fully gotten through, even with all that rollout beforehand. So I think it would have been a lot worse if we hadn't done all of that.

DR. STUART: This relates to the draft recommendation and it's a point that I've raised earlier.

When I read this, there's almost an implication that if you have Part D claims data then you can evaluate the Part D benefit. I don't think that's true. I think that in order to evaluate the benefit, you really need to have information about other health services that would be obtained from Part A and Part B claims.

One of the unintended consequences, I think, of making it more attractive for MA plans to offer these services is that then we have no Part A or Part B claims data for the individuals that are enrolled in these plans.

Now I recognize that this goes beyond the recommendation but I would like to see, at some point, that there is official recognition by this Commission that that lack of Part A and Part D data for individuals in MA plans itself is an impediment to program evaluation. It would

also be an impediment to evaluating public health consequences of Part D as well as safety consequences of Part D.

MR. HACKBARTH: In the next session, which is an update on MA and special needs, we will actually talk about a draft recommendation that you suggested related to MA information. So we will take that up today. It will be a draft and after that discussion we'll decide whether we want to proceed with it.

So let's focus on the Part D data recommendation now.

DR. CROSSON: I support the recommendation. I think it balances the need for information to evaluate the program, improve the Part D program for beneficiaries, with a set of proprietary concerns as are mentioned that have to do particularly with information about pricing and information about usage patterns, which while there is, I think, some interest in access that information it's also valuable to plans as tools to use in the process of negotiating for pharmaceuticals, with pharmaceutical companies.

And to the extent that plans are more successful

in doing that, it result in lower costs and lower costs can be passed on to the beneficiary. So essentially the recommendation balances, I think, two compelling values to beneficiaries and does it quite well.

MR. EBELER: Rachel, just a question. What do we know about rebate dollars in the context of this benefit? And does this recommendation help us know more?

DR. SCHMIDT: This recommendation does not directly deal with rebate data and we do not know the magnitude of rebate dollars. CMS does get data from plan sponsors on the value of rebates but it is not addressed within the context of this recommendation.

MR. BERTKO: As Jay said, I also strongly support the draft recommendation. I think the data is extremely important. On one level there's public health and monitoring of things that could come through the drug data. And on a second level, the risk adjuster that is connected with actually the movement of low income and dual folks, could be much improved.

Most of you probably recognize that because there was no Part D program the current risk adjuster uses Part A hospital and Part B physician data to project what the drug

costs will be by necessity. I've been working on a project to uses Part D data to predict Part D data and it is vastly superior. So just having that could potentially improve the risk adjustment, could improve the way plans are paid up and down on this and may, in fact -- my guess is it might reduce the amount of transition problems we have with the duals and low incomes.

DR. KANE: Quick question. This applies to both MA-PDs and the PDPs, I assume?

DR. SCHMIDT: That's correct. Both are submitting Part D claims data now.

MS. DePARLE: I have a question for John. How far away are you in that project from having something? And I'm sort of joking but sort of not, should we be making a recommendation on that? It sounds like a very good place to go to improve the risk adjustment system.

MR. BERTKO: The answer to that is a part of this project is submitting an article to Health Affairs. It shows the improvement for everybody except the low income. And then there's a second step to the project that intends to look at the low income separately.

But the improvement on I'll call it the regular

risk adjustment system is substantial. It goes from an R-squared of about 12 percent up to perhaps in the 30 percent range. So it's a significant improvement.

DR. REISCHAUER: I don't want to get off into a discussion of methodology for improvement of risk adjustment here, but I wonder if going the route that you're suggesting here doesn't embed in risk adjustment regional differentiations and utilization which may or may not be appropriate, given clinical indications, whereas the other method doesn't.

MR. BERTKO: Bob, you're correct on that. There certainly is the worry that drug usage itself, if done without proper consideration, would begin embedding that kind of thing.

My own guess again, as opposed to a knowledge with the research, is that you might be able to use categories as opposed to actual utilization in order to truly read the actual health burden on people rather the imputed burden due to prescribing patterns. But that's just a guess. My research friends are much better at that part of it.

MR. HACKBARTH: I know the Commissioners and the audience would love to continue this discussion on risk

adjustment methodology, but let's return to the recommendation. Any last comments before we vote?

Okay on the recommendation on the screen, all opposed to the recommendation, show their hands, please? All in favor? Abstentions?

Okay, thank you very much, Rachel.

The next topic is an update on Medicare Advantage. I think that comes first, does it not? And then we will discuss and vote on the final SNP recommendations at the end.

As I mentioned earlier to Bruce, during the MA piece we will discuss a draft recommendation on MA data.

Scott, whenever you're ready.

DR. HARRISON: In this session we will provide an update on the Medicare Advantage program, include a draft recommendation that Glenn just mentioned on data collection, remind us about our prior payment recommendations, and discuss our draft recommendations on special needs plans.

Just as a brief primer for commissioners who haven't seen some of this before, the Medicare Advantage or MA program allows Medicare beneficiaries to receive their Medicare benefits through a private plan. The Medicare

program plays MA plans a monthly capitated amount to provide Medicare benefits to the enrollees that enroll in the plan. Beneficiaries agree to give up their traditional fee-for-service Medicare coverage while enrolled in the MA plans. And currently about 20 percent of beneficiaries are enrolled in MA.

The Commission has maintained a principled position on payment policy for MA plans. The Commission has supported the concept that private plans can offer beneficiaries an important choice of health care delivery systems. Hopefully competition between MA plans and fee-for-service Medicare would result in increased efficiency and quality for Medicare services in the long run.

At the same time, beneficiaries choice of delivery systems should not be influenced by differing levels of Medicare payment, depending on which choice the beneficiary makes. We have stated that the Medicare program should be financially neutral in the beneficiaries' choice. In other words, the Medicare program should spend the same for a beneficiary who chooses any MA plan as it would expect to spend for that beneficiary to remain in fee-for-service Medicare.

If payments for all beneficiary choices were equal, then competition for enrollment among the MA plans and between plans and fee-for-service Medicare would be based on the efficiency of each delivery system and the perceived quality of care they provide. These principles motivate much of the payment analyses you will see later.

In some of the analyses, we talk about different plan types and other plan characteristics and I just want to define some of them for you here. The MA program includes several plan types. CMS classifies HMOs and PPOs as coordinated care plans, or CCPs. CCPs have provider networks and various tools to coordinate or manage care. CMS further divides PPOs into two categories, local PPOs and regional PPOs. The main difference is that, like HMOs, local PPOs can serve individual counties, while regional PPOs are required to serve entire regions which are made up of one or more complete states.

The MA program also includes private fee-for-service plans which do not typically have provider networks and generally do not have as much ability to manage care.

We sometimes make other distinctions. Jennifer will discuss special needs plans, or SNPs, in just a few,

minute. But here I just want to note that SNPs must be coordinated care plans and all numbers that I present here regarding CCPs will include the SNPs.

We also sometimes distinguish employer-only plans. These are plans that are not available to individual beneficiaries but only to employer or union groups. The employer-only plans may be any plan type and our numbers here include the employer-only plans except that our availability numbers do not include the employer-only plans because they are not available to all beneficiaries.

Enrollment in MA plans has grown substantially in 2007. From November 2006 to November 2007, enrollment in MA plans grew by 18 percent, or 1.4 million enrollees. There are now almost 9 million beneficiaries enrolled in plans, comprising 20 percent of all Medicare beneficiaries, and higher that at any time in the history of the program.

Enrollment patterns still differ between urban and rural areas. Despite strong growth in rural areas, only about 11 percent of rural beneficiaries are in MA plans while in urban counties about 23 percent of Medicare beneficiaries are enrolled in plans.

There are large enrollment differences between

plan types. While private fee-for-service plans account for only about a fifth of total MA plan enrollment, they accounted for about 60 percent of total enrollment growth. There are now about 1.7 million private fee-for-service enrollees, more than doubling in the past year and increasing by more than eightfold over the past two years.

Meanwhile, growth in coordinated care plan enrollment was only a modest 8 percent and all of that growth was actually in SNPs and employer-only plans. Currently, there are a million enrollees in SNPs and another million in employer-only CCPs. And for the record, another 300,000 in employer-only private fee-for-service.

Although not on the slide, I want to note that rural enrollees are increasingly more likely to be in private fee-for-service plans. Over half of all rural plan enrollees are now in private fee-for-service.

Now let's look quickly at plan availability. MA plans are available to all Medicare beneficiaries, as has been the case since 2006. This was a significant increase from 84 percent of beneficiaries in 2005.

The only real change here is the number of plans available. Medicare beneficiaries will have more plans to

choose from in 2008. Excluding the employer-only and the special needs plans, an average of 35 plan options are available in each county in 2008, compared with about 20 plan options offered in 2007.

I'm now going to shift to plan payment issues. I mentioned that MA plans are paid capitated rates and those rates are based on the plan bids and on administratively set bidding targets or benchmarks. I'm afraid I don't have time to go into detail about how the benchmarks have been set but in short they are set by county, they are at least as high as the county's per capita Medicare fee-for-service spending, and most benchmarks are higher than fee-for-service because of legislatively set floors and for other technical reasons.

Plans submit a bid for the basic Medicare benefit and it is compared with the benchmark. If the bid is higher than the benchmark, the plan is paid the benchmark and beneficiaries should pay any difference with a premium.

If the plan is below the benchmark, the plan is paid its bid plus 75 percent of the difference and the remaining 25 percent of the difference is retained by the Medicare program. The plan is then obligated to rebate its

share of the difference to its members in the form of extra benefits, namely lower cost sharing, supplemental benefits, or reduced premiums.

I'm sorry for the brevity on a lot of this, but if any commissioners need further detail, I can take it on question.

Our analysis of plan benchmarks and MA payment levels in relation to Medicare fee-for-service expenditure levels above shows that benchmarks in MA program payments continue to be well above fee-for-service levels.

We previously found that program payments to MA plans in 2006 were 112 percent of spending for similar beneficiaries in Medicare's traditional fee-for-service program. Here we update the analysis using new enrollment data for November 2007, the 2008 benchmarks, and 2008 plan bid information. The new analysis shows similar, although somewhat higher results, which MA payments at 113 percent of fee-for-service spending.

We don't show the old values on the table but both the bid and benchmark ratios have gone up a couple of points and now we find that the average bid is 101 percent of fee-for-service spending. This means that beneficiaries on

average are now enrolled in plans that are less efficient than fee-for-service Medicare. It does not mean, however, that all plans or even all plan types are inefficient. HMOs are able to bid an average of 99 percent of fee-for-service.

At the same time, the bids from other plan types average at least 105 percent of fee-for-service spending.

Overall, these numbers demonstrate that HMOs can be more efficient than fee-for-service while other plan types tend to be less efficient. These bids, combined with benchmarks well above fee-for-service produced payments to plans that are well above fee-for-service spending for all plan types. HMOs and regional PPO payments are estimated to be 112 percent of fee-for-service, while payments to private fee-for-service and local PPOs will average at least 117 percent. These payment ratios are all two points higher than we estimated for 2006, except that private fee-for-service is two points lower. The reason for that exception is that private fee-for-service plans have expanded and are now available in all areas and they are now drawing enrollment from counties with lower benchmark ratios than they did before.

We also looked at the SNPs and employer-only plans

because they're bidding behavior differs from the mainstream. SNPs were able to bid lower relative to fee-for-service than any other group of plans.

On the other hand, employer-only plans tended to bid higher than other plans. Their bids, at 108 percent, result in payments averaging 116 percent of fee-for-service spending. Although we don't display it on this table, we examined the employer-only plans within each plan type and found that employer-only plans consistently bid a couple of percentage points higher than plans open to all Medicare beneficiaries.

We are concerned that because these plans do not have to market to individuals, their Medicare bids may not be as competitive. After the bidding process, employer-only plans can negotiate more attractive packages with each employer group that may result in Medicare payments subsidizing employers supplemental costs. Thorough auditing by CMS is required to ensure that such cost shifting is not occurring.

MR. HACKBARTH: Scott, before you leave this table, all of the changes in these numbers are attributable to shifts in enrollment patterns as opposed to changes in

payment policy; is that true?

DR. HARRISON: That is generally true, and also that some of the bids have been a little higher.

MR. HACKBARTH: Okay.

DR. HARRISON: I would now like to present a draft recommendation that has arisen from commissioner comments at the previous meeting and, indeed, the previous session. Plans do not generally provide encounter data to CMS that details of services that are provided to each enrollee. If CMS collected encounter data, it would help explain plans' relative costs for different types of enrollees and help determine best practices that might translate to the fee-for-service system. It may also inform questions about the relationship between Part D offerings and the use of other health services.

However, this data collection will likely impose new burdens on CMS and at least some plans. While we believe many MA plans collect these data in order to pay claims, we also know that some plans with large MA enrollment are not currently able to produce this data. The commercial market, however, may begin requiring more of this information. So in the near future, many plans may need to

develop this ability in any case.

The draft recommendation reads: CMS should require plans to submit counter data that would detail the Medicare services provided to enrollees.

There would be spending implications if plans raised their bids to cover data collection costs. We don't see any implications for beneficiaries or plans other than the data collection burden on plans that do not already collect the information.

I want to conclude my section of the presentation by putting up our recommendations from our June 2005 report which was the last time we made formal recommendations on the Medicare Advantage program. This will serve as a reminder of our positions on Medicare Advantage because they will be included in the MA chapter.

We recommended that Congress should set the benchmarks at 100 percent of fee-for-service costs. And if the benchmarks are set at 100 percent of fee-for-service costs, we further recommended that any savings from plans bidding below those benchmarks should be redirected to a fund that would redistribute the payments back to the plans based on their performance on quality measures.

We also made several other technical recommendations, some of which have been addressed in subsequent legislation.

Now I want to turn it over to Jennifer for special needs plans.

MS. PODULKA: You've heard much of this last month and the month before so I was going to go through it quickly, but just to remind you, special needs plans were added as a type of MA plan by the 2003 MMA. They are paid the same as other MA plans and subject to the same requirements. The only difference is that all SNPs must offer the Part D drug benefit and they are allowed to limit their enrollment to their targeted population. This authority to limit their enrollment will lapse at the end of 2008 unless the Congress acts to extend it.

And SNPs targeted populations include three types of beneficiaries: those who are dually eligible for Medicare and Medicaid, institutionalized beneficiaries or those who live in the community but are nursing home certifiable, and finally those who are chronically or disabled.

There are aspects of SNPs that raise concerns. We are concerned about the lack of Medicare requirements

designed to ensure that SNPs provide specialized care for their targeted populations and SNPs resulting lack of accountability. This raises questions about the value of these plans to the Medicare program. For example, dual eligible SNPs are not required to coordinate benefits with Medicaid programs and many dual eligible SNPs operate without any state contracts.

Second, since they were introduced, SNPs have grown rapidly, both in terms of number and enrollment. Currently, there are more than 400 SNPs and next year there will be more than 700. Also, by next year, 95 percent of beneficiaries will live in an area served by a special needs plan. And currently, SNP enrollment has grown to more than one million beneficiaries.

Third, organizations entering the SNP market include those with specialized experience with Medicaid and special needs populations but also include MA organizations with no such experience that chose recently to add SNPs to their menu of plans, possibly to take advantage of year-long marketing opportunities. This raises a question of whether this represents a marketing strategy or a real investment in providing specialized care to targeted populations.

Before we discuss the specific SNP recommendations that will follow, I want to remind you that as SNPs are an MA plan type, the MA recommendations that Scott just described apply to SNPs, as well. I also want to remind you that as a MA plan type, SNPs receive similar excess payments, as all MA plan types do. That means that any extension of the SNP authority carries with it a budgetary cost. Some of the draft recommendations that we'll discuss help to mitigate the overall cost but not to remove it. Because we have an entire package of recommendations, I'm going to save the budget score discussion for the final of our seven recommendations. So for each one I'll discuss implications for beneficiaries and providers but only on the final one will I give you a total package budget score.

Which brings us to draft recommendation one, which is that the Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.

As I noted, we're concerned about lack of Medicare requirements designed to ensure that SNPs provide specialized care for their targeted populations and the

resulting lack of accountability. Currently, SNPs must measure and report the same quality measures as other MA plan types do. We want them to continue to do so so that we can have that comparison, but they should also be subject to measures unique to SNPs. The implications of this draft recommendation is that benes would receive improved quality of care while plans would have the additional burden of reporting this new information.

Draft recommendation two is that the Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance to other MA plan types, as well as traditional Medicare.

The implications here are that the recommendation would improve beneficiaries' ability to make informed choices about SNPs while having minimal impact on plans as they already submit this data to CMS.

Draft recommendation three -- first, let me note that the MMA allowed the Secretary to designate plans that disproportionally serve special needs individuals as SNPs. CMS has defined this to mean that the percentage of the target population in the plan must be greater than the

percentage that occurs nationally in the Medicare population.

This undermines the original intent of SNPs, which was to serve special needs beneficiaries as defined by the MMA legislation. The current disproportionate share standard is too liberal and untargeted. It allows plans to select among potential enrollees who fall outside the three defined target populations based on criteria that could differ by plan. Although there may be legitimate reasons for SNPs to enroll other beneficiaries, these exceptions should be limited and defined.

So draft recommendation three is that the Congress should require special needs plans to enroll at least 95 percent of their members from their target population.

The implications for plans is that some would have to alter their enrollment or cease to be SNPs. If they did, they could continue as regular MA plans. And as a result, relatively few beneficiaries would have to either switch plans or return to fee-for-service.

Draft recommendation four is that the Secretary should require chronic condition SNPs to serve only beneficiaries with complex chronic conditions that influence

many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems. I want to note that we would envision the definition here to go into effect in the near term.

To further refine the definition, the Secretary should convene a panel of clinicians and other experts to create a list of chronic conditions and other criteria appropriate for chronic condition SNP designation. The list of conditions and other criteria should be issued as a proposed rule with comment and final rule within a three-year period to allow policymakers time to make future decisions about extending SNP authority.

Also, as part of those "other" criteria, the panel should identify the appropriate stage or severity level for each condition for SNP designation.

Draft recommendation five is that the Congress should require dual eligible special needs plans to contract either directly or indirectly with states in their service areas to coordinate Medicaid benefits within three years. And noting here that recommending that all dual eligible SNPs should contract with states within three years means

that by 2012 any existing, as well as any new dual eligible SNPs, could only begin operating if they started with a contract in place.

Since the recommendation is designed to take effect in 2012, while pursuing contracts in the meantime, dual eligible SNPs should be required to limit enrollees' out-of-pocket cost-sharing to no more than Medicaid cost-sharing in those service areas. To ensure that SNPs are not given an unfair competitive advantage over other MA plans, their bid should be required to reflect actual negotiated provider payment rates and beneficiary cost-sharing.

I also wanted to note some commissioners have raised concerns about the contracting language and what is included here should not be interpreted as calling only for capitated payment amounts. States could certainly contract to pay at Medicaid fee-for-service rates. We would also envision that the contracts would include things like marketing and appeals and other aspects besides payment.

We welcome CMS's efforts to encourage greater state/SNP integration and would like CMS to do even more to facilitate collaboration between states and SNPs. However, it is unrealistic to expect all states to enter into

partnership agreements with all entities that wish to offer dual eligible SNPs. Not all states may see value in each of these plans and they may have a legitimate role in serving their dual eligible beneficiaries in determining which plans they wish to contract with.

Furthermore, some dual eligible SNPs in place have already been successful in achieving greater coordination with states. Thanks to Jennie, we have a new piece of information, that by the end of 2008 32 states will contracts in place to coordinate Medicare and Medicaid financing for the PACE programs.

Finally, on draft recommendation five, the implications are that beneficiaries would enjoy greater coordination of their Medicare and Medicaid benefits. And for plans that were unable to contract with states, they would either have to cease to be dual eligible SNPs or they could continue as regular MA plans.

Draft recommendation six is the Congress should eliminate dual eligible beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-

service at any time during the year.

I want to note that this recommendation, because it applies to dual eligible beneficiaries, it is the recommendation in these seven that I discussed that one affect all MA plans and not just special needs plans.

It is designed to help protect duals from the unintended consequences of previously exempting them from lock-in. Because dual eligibles can change MA plans on a monthly basis, they are subject to, at times, alarming market abuses. I want to note that staff conducted focus groups specifically on Part D. They didn't even ask about dual eligibles in MA plans. And in all 12 focus groups, at least one member mentioned horror stories about marketing abuses to duals.

I also wanted to note some of the special exemptions. If you think of open enrollment and how it applies to beneficiaries, you can think about three levels. First, all beneficiaries in MA are eligible to enroll and change plans during an open enrollment period. On a second level, beneficiaries can change plans outside of open enrollment for certain life events that trigger defined special election periods. For example, when they enter a

nursing home, when they move residences to a new home, when they first gain their Medicaid eligibility, and for other life events.

This third level is the only one that applies to duals, and that's continuous year-round enrollment where they can churn from plan to plan, month-to-month. And so this recommendation is designed to move duals back into that second level where they can change for life events.

Note that it would let them get out of a plan that they disliked or to enroll in a special needs plan with state contracts at any time during the year. Of course, it would allow them to change plans when they experience life events.

Also, I'd like to note that CMS has made the specific accommodation for duals who lose their Medicaid eligibility month to month, as they have allowed plans to keep these beneficiaries enrolled for up to six months.

The implications for beneficiaries are that they would enjoy greater protection from plan marketing abuses. And for plans, there would be potentially a significant impact if it reduced plan enrollment.

This brings us to our final draft recommendation,

that the Congress should extend the authority for special needs plans that meet the conditions specified in recommendations one through six for three years.

Here's where I'll discuss the total budget package. The spending for all seven recommendation should be viewed as a package. Therefore, the entire package spending implications are that it increase Medicare spending relative to current law by $50 million to $250 million for the year 2009 and by less than $1 billion over five years.

The implications for beneficiaries and plans are that they could continue to be enrolled in and operate special needs plans during an additional evaluation period. I would like to note that we suggest three years to give the Secretary time to implement all new rules, collect performance data from plans, evaluate their performance, and report the results in time to inform future decisions about extending SNP authority. Remember that the current SNP authority actually expires at the end of next year so this recommendation would work out to be sort of a de facto four-year extension as it would run through the and of 2011.

That concludes the recommendations and we look forward to your discussion.

MR. HACKBARTH: On the last one, just on the budget impact, is that impact due solely to the fact that the current baseline, current law baseline, assumes that SNP authority will expire at December 2008?

MS. PODULKA: Correct.

MR. HACKBARTH: We have a lot of material to cover here, so what I'd like to do is structure the discussion period. I'd like to focus first on the SNP recommendations and go through them in order and get comments on each or questions about each. Then after we do the SNP recommendations, I would take up the draft Medicare Advantage recommendation. And then after that, if we have additional time, we can have some general discussion about the MA update. So that's the plan.

So with recommendation one, SNP recommendation one, on the screen, any questions or comments about that recommendation?

Okay, let's put up number two. Any discussion of number two?

MS. HANSEN: I apologize. I just want to go back for a clarification on number one. With some of the special evaluation tools, we're using some of the studies that are

coming out of NQF relative to special measures for SNPs; is that right?

MS. PODULKA: Yes. There's actually a couple groups, at least, that are working on special needs plans specific measures, including CMS, NCQA, NQF. We'd like to see those. There may be additional ones that should be included, as well.

MR. HACKBARTH: Mark reminds me, just for the benefit of people in the audience who have not been following our deliberations on these issues, we've had several sessions now on SNP issues and draft recommendations. So the commissioners have seen either these recommendations or variations of them now multiple times. So if the discussion seems perfunctory to you, it's not because people don't have any questions to ask. It's because we've discussed these so thoroughly already.

So number two, going, going, gone.

Number three.

DR. KANE: Just so you know we are awake here, I'll have a few comments.

I'm very concerned that this is unnecessarily restrictive at this point. A couple plans have come through

and obviously we're concerned about abuses. It's not clear to me that the response should be shut it down and not allow plans to get waivers if they have some way to provide innovative services to a population in need.

I would prefer that the Congress require the Secretary to form a panel of experts to create very specific criteria on what would constitute a program that would be eligible for a waiver and that the criteria be realistic and truly identify people who are in need of special services that the SNP can provide.

There could be a need to demonstrate that they have a selected primary care network or that they can manage care continuously from the hospital through the skilled nursing to the home setting, that they have an electronic medical record or home visits or same day evaluation for urgent problems. There's a host of things that you could say you have to be able to demonstrate to be able to get a waiver. And I think it would help us also define what is a SNP and what services should it provide.

You could have something like a risk score minimum that's well above what the natural Medicare population has.

I'm just afraid that what we don't have down here

on implications is that we're setting off the opportunity to innovate and I think that's what SNPs were for. That the waiver process maybe needs to be tightened up and that Congress may need to direct the Secretary to tighten it up. But in just saying no more waivers because a couple of plans have already abused it seems overly restrictive at this point.

MR. HACKBARTH: Just a question about how things work now. If a SNP is enrolling people outside of its target population, what rules apply? Do they get to pick and choose who they enroll? And if so, doesn't that raise questions about risk selection?

MS. PODULKA: As we understand it, once you apply and receive the disproportionate share waiver, the additional people you pick outside of your target population are up to the discretion of the plan and not necessarily subject to enrollee by enrollee oversight.

MR. HACKBARTH: What I hear you saying is yes, it's just open season. They can say we'll take that person but not that person?

MS. PODULKA: That's a very real concern.

MR. EBELER: Nancy has raised this. I think it's

an interesting point. I think the difficulty with not setting a new standard in this area, like recommendation three, and in particular not setting a statutory one and sort of relying on another regulatory process is reflected in previous discussions the Commission has had, which is we're not at all sure this program is meeting its intended objectives at all. The balance of whether one should extend this or shut it off in some way is a tough one and we're making that judgment with hopes but without a whole lot of information.

There are clearly some good guys out there, and we all tend to talk to the good guys, and they're trying to do good things. But this program is exploding. And all of the analyses are overwhelmed by the payment level.

So it just strikes me that we need sort of very clear criteria here during this period of time to find out if special needs plans are vehicles for actually meeting the needs of people with special needs. I think that's the trade-off.

MS. DePARLE: I agree with Jack. I'm all for innovation but I think maybe there's been a little bit too much innovation in this so far and we need to put some speed

barriers up.

MR. DURENBERGER: I agree with both Jack and Nancy and with what Nancy-Ann just said. I think there was more innovation before this program went into effect than there has been since then. And that's the concern, part of the concern that both of them have expressed and perhaps come to different conclusions.

The challenge, I think all of us have faced in our discussion in talking about the needs plans in the context of this population, is it's a difficult population. These are not "consumers" in the language of Republican reformer, marketing reformers. These are people who cannot self-diagnose and then go make a choice of a health plan to meet their diagnosis. One of our previous recommendations uses the word counselors and that is the more typical way in which we see some of these choices being made.

So as a result, as all of us know by now, there are special needs plans that have been out there for some time. There are new special needs plans. That's particularly true in states that Nancy and I live in and have some experiences with, that really add a lot of value. That's why the whole concept has come to the fore.

But now there's an increasing number whose main value is to the needs plans itself, and you can see that just by the numbers that are expanding. That fact challenges the ability of the more valuable plans to do their work.

So I agree with exactly what Jack has said. It doesn't help solve any of our problems. But I also think that CMS has done little or nothing to try to deal with that particular problem and just seemingly opening the floodgates to anybody who designs a plan that meets general specifications to go out and start peddling those plans.

Nancy, at least, has come up with a suggestion -- I don't know whether it's a modification of this or what it is -- but she's come up with a suggestion that we ought to spend a little time recommending some specific criteria that CMS must use over time in judging what is a special needs plan and what is not.

I don't know what you intend to do with your comments, but I'm inclined to support them as some form of notification of number three.

DR. MILLER: One way to think about the structure of the recommendations here is to the extent that the

innovations are to be designed around clinical types of models, so this kind of the disease and this kind of progression, as we move through the recommendations you'll see that there's been a push to say that the Secretary needs to define what a chronic care plan is.

We think the institutional plans have some degree of definition, and of course the dual eligible plan is kind of a different animal. It's not clinical, it's insurance really.

So one way to think about the structure of the benefits is to the extent that the Secretary steps up and sets guidelines through what Jennifer described as this process of experts and then making a regulatory statement, what this one does is it says that now that those guidelines exist, make sure that you fill the plan with those people who meet those guidelines. It's in a sense sort of turning Nancy's point on its head.

The concern that has come up in some of our conversation -- I think Bill has said this -- is that if you leave the exception in the Secretary's hands it's not clear, certainly from the current information, that strict guidelines will be set. So that's one way to think about

the structure of the recommendations as they stand.

Is that what you were looking for?

DR. SCANLON: I would just echo what Mark said. I don't think of this as a threat to innovation at all because I think that the key here is how you define the target population. If I were to bring the expertise together with the Secretary to define that, I think that would address Nancy's concerns in terms of get the right people. And then this is saying the plan is targeting them. These are the people that are going to be part of the plan.

Now we could potentially envision that you have a waiver for something like a hybrid plan, something that's a dual/chronic plan. That would allow for a little bit more flexibility.

But again, we're talking about something that's gotten out of control and we're trying to say let's have some standards here in terms of what we are actually paying for and trying to examine whether or not there's value in the innovations that are occurring.

DR. KANE: I agree that that's what we're looking for really, is something that says let's say what the standards are. I'm not sure how to take these

recommendations on a one by one basis. Do we say we only approve them as a complete package where, in fact, a target population can include more than just a dual eligible but could be a hybrid?

So part of the problem is this, on a stand-alone basis, says we're basically saying a waiver is not going to happen if you want to do a dual. And that's my concern. It's too blunt. So if we want to say target population may include SNPs that are hybrids or may need to be further defined beyond the categories that currently exist, then I would understand. Then it could be 100 percent of their members. Why allow anybody in whose not part of the target population?

So I guess I just feel like we need to say what we mean by target population if we're going to now say it can be outside the traditional categories of SNPs that are set up right now.

So I would like to see criteria established that say SNPs should meet those criteria, current ones and ones looking for waivers. And then within that you should be able to enroll 100 percent of your population that meet those criteria. Right now this is just saying you can't

have a waiver and there's no other way to deal with going beyond the categories that currently exist.

DR. SCANLON: I was thinking of sticking with the categories that currently exist, in part to deal with the point that Glenn made, which is not to grant waivers to allow a plan to have discretion to decide yes or no on anybody that applies to the plan. But the issue would be that I could potentially -- if I've done a good job of defining the chronic conditions that are going to qualify, then I could have some people from the group as well as some duals.

You could change his recommendation to at least 95 percent of their members from the target populations. That sidesteps the issue of whether or not it's a waiver, whether or not it's a hybrid plan. And it deals with the problems that we've seen, which is that we've got plans that are less than a quarter from the target population and three-quarters from the general Medicare beneficiary population.

MR. HACKBARTH: I do see these seven as a package, as opposed to individual. Part of the design of the package is to tighten up what we mean by a SNP and what we expect them to be able to do in order to gain these special rules.

And once you do that, I think it's entirely appropriate to say you ought to enroll these people and not others.

And so that's the logical flaw that I see in this package. And it sounds like you agree with that except you would like to acknowledge that maybe we need some, for example, SNPs permitted that combine chronic and duals.

If that's the issue, maybe that can be addressed in our discussion of -- I don't know what number the recommendation is -- but one of the other recommendations where we talk about specifying the criteria.

DR. KANE: My original solution was to drop three and clarify I think it was four with much more specific language about -- that everybody should be fitting these criteria but that those criteria have to be well defined. I don't see any reason to enroll people who are healthy in these.

DR. MILLER: I'm not convinced that as we've got things structured you can't contemplate a situation like that without actually -- and I'm kind of looking for some assistance here from the staff -- that you couldn't contemplate a situation. So for example, in the SNP that you're working with in Massachusetts, it's a dual eligible

SNP and has a state contract to coordinate benefits. So in a sense, a functioning dual eligible SNP very much the way we're sort of looking for them to function.

To the extent that it wanted to change its mission and say I also want to bring people in that are not dual eligible yet, because I have a chronic condition that I want to catch and manage before, that SNP could operate as a chronic condition SNP with a state contract to coordinate its dual eligible benefits.

And so even as drafted, I don't see how the innovation did you're reaching for is actually excluded by this set of things.

Now I'd like a staff person or two to tell me that I'm not out of my mind.

DR. HARRISON: I believe that states are allowed to designate subpopulations to be in a SNP. I think, for instance, Massachusetts doesn't allow the disabled into the SCOs; is that correct? I think that there is that power right now. I don't know if Carlos or somebody else from CMS...

MS. THOMAS: Another possibility would be you could also have two contracts side-by-side. So you wouldn't

necessarily have one hybrid. Imagine that most of the SNPs snips coming with MA plans and they're essentially side-by-side contracts.

MR. HACKBARTH: So what you suggesting, Sarah, is one legal entity, not have two legal entities. But one legal entity, just with two contracts. Many plans have multiple contracts with multiple payers.

MR. EBELER: You've flagged a little bit of a logic issue which is in our sequencing. It may well be that as we discuss these number four, which is the much better clarification of what a chronic condition would be, what a chronic condition SNP would be, is the first one one should articulate. Having articulated a better definition of what that is -- I think you do -- then saying so you actually have to serve that target population.

As I read the phrase target population if, given that new definition, is a SNP chooses to include duals as well as other people, that is their target population and that's fine. The point is you've got to do what you said you were going to do.

So there's a logic in sequencing we might think about here in how we present this.

MR. HACKBARTH: I'm starting to worry about that time.

I think Jack's point about the logical flow is a good one. When we write this up we can switch the order so that it flows that way.

Then I think through language in the text we can make some of the points that have been made here, that we're in favor of legitimate innovation. And if it involves a plan serving both duals and certain chronic conditions, we're not opposed to that. We think that that can be accommodated and should be accommodated within the existing framework. For example, as Sarah has suggested, multiple contracts.

But once the rules are set, they need to be enrolling these people. I'm really troubled by the response to my earlier question that they get these waivers, they've got a large percentage of the population isn't the target population, and they're picking and choosing among them. That's appalling.

DR. KANE: Just a last point, I'm appalled by that, too. I think 100 percent of the population should be from the target. Why 95? But the target has to be very

clearly enunciated by somebody who says here's what a SNP is.

But it should be a little looser than you've got to be categorically eligible. Even chronic disease SNPs, are they broad enough to include the multiply chronically ill, slowly deteriorating person?

So I think we need to say here's the clinical needs, not the category, and be broad enough that the target population can be clinically determined as opposed to categorically determined. I think that's where the waiver looked like it created opportunities and I just didn't want to lose that.

MR. HACKBARTH: Okay, we need to keep moving ahead to stay on schedule. So we are now at number four.

DR. CASTELLANOS: I guess my concern really here is that in the previous recommendation we had the Secretary to establish a panel. And it's in the context. I'm just concerned that is that strong enough? Or should we put in the recommendation?

As you know, SNPs are designed around clinical grounds and it's important to have clinicians evaluating this and not, for a better word, bureaucrats. Again, the

example is the cholesterol. It's outrageous, in my opinion, to have one just for elevated cholesterol.

Jennifer, I really like what you said in your context but I would like that -- if it's not strong enough, I would like that as part of the recommendation, that the Secretary convene a panel of clinicians and other experts to create criteria appropriate for chronic conditions.

DR. DEAN: I had a couple of concerns about this one. First of all, just on the issue of chronic conditions, within every one of these potential diagnoses there is a huge spectrum in terms of complexity. I would argue, even though we've sort of made fun of it, even within the elevated cholesterol.

There is a small percentage of people with high cholesterol that I take care of that might actually benefit from a focused approach because there's a few of them that are really complex. In most of them it's not that big a deal. You've just got to get them to be a little careful about their diet and take the medicine and that will take care of it. But there are a few that are really much more complex.

And so I would have a very difficult time -- and

the same applies to diabetes or heart failure or hypertension or any of the other things that might possibly fall into this category. I would have a hard time figuring out which ones should go into a plan like this and which ones shouldn't.

The second thing that I'm even a little more troubled by is the final phrase "require specialized delivery systems" because my experience so far with at least the disease management programs that a number of insurance companies have tried to implement is they really get in conflict with a lot of times what the primary care system is trying to do. And in the absence of really an integrated system where you have both the payment systems and the delivery systems is really part of the same operation, people get really conflicting -- even if there's general agreement about what the guidelines should be, you get conflicting recommendations to the recipients, to the beneficiaries.

It just brings to mind an old fellow that I take care of who has VA benefits. He's anti-coagulated and so I see him pretty regularly to manage his Coumadin. And he also involved in a cardiovascular special needs program

that's available in our area. And so he has got three different organizations basically directing his care.

It was soft of amusing because so far the special needs plan hasn't done anything. They're just paying his benefits. But I asked him the other day, so what is this plan doing for you? He was all pleased because it did have some extra benefits that he didn't have before. And he says well, they sent me this big old book but I didn't read none of it, he said.

And I think that that is not an unusual reaction. It sort of fits with what Mitra said about your attempt to educate people. You educate people by sending them literature, you're dreaming if you think that that's really going to change behavior.

It will for a few. But for a lot, it's got to be a whole lot more aggressive.

So I would be much more comfortable, and I don't even know exactly how to do it, that somehow there be -- and maybe it could be in some of the text, that some push that these plans need to work with the existing delivery system because one of our concerns we've talked about in other discussions is the fragmentation that really is at the heart

of a lot of the problems that we are encountering. And I think this has the potential to really aggravate that.

DR. MILLER: If I could just say one thing, it may have been the choice of the words here, but precisely what you described is what we're trying to get away from. The notion that someone would come in, collect these payments, and send a booklet is not what we're talking about here.

And our attempt at specialized delivery system, whether the exact words are right, was the notion that someone has actually formulated a program in which they're contact with people who can actually help them manage this benefit.

I have to say without consulting, I don't think we have any problem in that text trying to describe what you've just said because then it is, I'm pretty sure, what we were reaching for. Now we may have picked a word that someone didn't fit right in your thinking. But what you described is the very problem that we're trying to overcome.

DR. DEAN: I sort of assumed that. The problem that even the so-called disease management programs a lot of the insurance companies already have implemented, I think had the same motivation. And in fact, the net effect was

conflict.

DR. WOLTER: At this point, Tom is making good points. I read this differently and I read the words delivery system fairly specifically. I guess I would go back to the work we did on chronic disease management in the past, that Karen Milgate did. I think I saw her walk in the room earlier. We actually talked about some different models of chronic disease management. Some were integrated delivery systems, some were primary care based but had some other support.

But this is a very important recommendation and it's very important because if we're going to spend this money and we manage these people well, we're going to improve function, decrease hospitalization, and we're going to have pay back that we could measure to the extent that we're also requiring better measurement. So I think this is a very important recommendation as long as we clarify some of these points.

DR. DEAN: I should have prefaced what I said. I totally agree with the direction or the theme of this, absolutely. I was worried about some of the wording and that it's really more complex than I think maybe we realize.

DR. SCANLON: I agree about this being important. I think it's probably one of our most important of the seven recommendations. I guess I would raise the question of parallelism. Five of our seven recommendations we're asking the Congress to define the SNP program. This one we're deferring to the Secretary. I would say this one should be another one where we're saying the Congress should specify that chronic condition SNPs serve a correctly targeted population.

MR. HACKBARTH: Other comments on four? What I propose to do, Tom, is try to address your issues through discussion in the text where we're not so constrained about choosing one word. We can use a paragraph or two paragraphs, or whatever, if necessary, to convey the meaning.

Let's move on to five.

MR. DURENBERGER: I just have a question about what does within three years modify? Is it the contracting or is it the coordinating? It's unclear to me. Do you coordinate within three years or do you contract with three years?

MS. PODULKA: The contracts are to life out the ways that the plan will coordinate with the state Medicaid. So within three years you should have some sort of contract in place, direct or indirect, that specifies how you will coordinate the Medicaid benefit.

MR. HACKBARTH: But the specific response is within three years modifies contract.

MR. DURENBERGER: So we could move that up after "plans" and before "to contract" or something like that.

MR. HACKBARTH: To require dual eligible special needs plans within three years to contract, either directly or indirectly...

MR. DURENBERGER: Thank you.

MR. HACKBARTH: Others on number five?

Number six?

DR. SCANLON: The concern is about the chronic condition SNPs and the fact that the current enrollment opportunity is rather vaguely defined. It's while you have a condition until you enroll in a SNP, which is in some respects continuous open enrollment. I think that we should think about how to address that as well, in terms of limiting that period.

So it would be something along the lines that if you are newly in a situation where you qualify for a chronic condition SNP that you have a period of time, say 60 or 90 days, in which to enroll. Otherwise you wait for the next open enrollment period.

MR. HACKBARTH: Refresh my recollection, Jennifer, in terms of the existing enrollment rules. Is there not a special enrollment opportunity for people with a new chronic condition?

MS. PODULKA: There is a special election period for people specifically for chronic condition SNPs, and that's when you are diagnosed -- and we've discussed that that can be a little squishy -- diagnosed with a condition or a disabling disease, until you enroll in your chronic condition SNP you have an open special election period. so that could stretch for the full 12 months of the year.

MR. HACKBARTH: And then once you do it for the first time, you're subject to the normal enrollment rules?

MS. PODULKA: Correct.

MR. HACKBARTH: Doesn't that address your issue, Bill?

DR. SCANLON: The concern here is on the plan

side. It still creates an opportunity for continuous marketing and enrollment because -- we've talked about this as a problem in terms of churning. But I think there's also an issue of keeping marketing going on throughout the year.

MR. HACKBARTH: Then I'm sorry, I'm missing your point. So would you go back to the beginning and just restate what you want to accomplish?

DR. SCANLON: What I want to accomplish is that an individual that qualifies for a chronic condition SNP has an opportunity to enroll when they qualify, they don't have to wait until the end of the year.

MR. HACKBARTH: They have that.

DR. SCANLON: They have that now but they now have -- if I qualify on January 15th, I now am able to enroll all the way through the end of the year, as opposed to --

MR. HACKBARTH: So you want a narrow window.

DR. SCANLON: Narrow the window so that we don't create the incentive for plans to market sort of year-round to these individuals, particularly if we don't succeed on the recommendation with respect to defining chronic condition SNPs. We've brought up a number of times the example of the high cholesterol SNP.

MR. HACKBARTH: So the narrow window would be --

DR. REISCHAUER: But they will market year-round, just to different people. So I don't see what you're getting at here.

DR. SCANLON: The issue here is try to understand why do we have close to 800 SNPs. I think it's the issue of opportunity. The marketing, there's an issue of intensity of marketing.

This is to try and say we're not putting out here something where you're not going to operate within our predominant rules, which is that we're going to have open enrollment periods, we're going to have limited enrollment during the course of the year. Because I think that's what's happening here with respect to SNPs.

DR. REISCHAUER: But in some cases the event, as Jennifer said, is a little squishy that qualifies you for this open enrollment period, whether it's the balance of the year or, as you want, three or six months.

DR. SCANLON: There's no question that it's hard to draw precise boundaries. But the question is now we don't have any boundaries.

DR. KANE: Except that they can only enroll once.

And I think that's what you want. Relating to what I was told, which is a lot of these people have been in a slowly deteriorating situation and finally some caregiver says you need to be in this. And that's how they're recognized, is the provider system refers them in. I think as long as they can get it once but not six times you've done the job.

MR. HACKBARTH: Which is the current situation, as I understand it. There's one opportunity to enroll outside of open enrollment as a result of the onset of a new condition and it happens once and then it's over for that beneficiary. The plan can continue to look for other people off-cycle but each beneficiary has a one-time opportunity.

Then the question would be can you narrow down that window? And given the squishy definitions, I think it might be practically very difficult to enforce a tight regulation and a narrow window. And so the lever that's easiest to pull is it's a one-time opportunity per beneficiary.

DR. SCANLON: The recommendation about defining chronic condition is actually much more important. And if we can succeed on that, then this one becomes moot. If we fail on that, I'll worry about this.

MR. HACKBARTH: We need to keep moving ahead. Is this still on six?

MR. DURENBERGER: Just briefly, and basically for the information of people in the audience, I think that we've had a couple of weeks of very intense discussion on this issue and the modifications here may not be perfect. But I think everybody understands what they're intended to do. I want to thank Jennifer, in particular, for communicating with a lot of people in the last couple of weeks, particularly to get the state Medicaid people's interest in this and others. It's been a very, very helpful process.

MR. HACKBARTH: Anything else on six?

Let's move down to seven. Any comments on seven?

DR. KANE: Actually I think I do. So we think it should end if recommendations one through six in their entirety are not met? That's the null? Is that our alternative recommendation? I just want to clarify what we're saying here.

MR. HACKBARTH: The intent that we're trying to convey is that we support the extension but only with important conditions. And the conditions are embodied in

one through six.

Now these are not all concurrent events. Some of them are asking the Secretary to develop standards and measures and whatnot. That's not going to happen when Congress is considering the legislation. So these things are going to unfold over a period of time.

But we thought it was important to convey that this is not a blanket endorsement of extending SNPs, and it was important to have in the bold faced print, it is only under certain conditions. That's what we're trying to accomplish. We can use the subsequent language in the text to explain why we've framed it this way.

Did you have a comment, Bob?

DR. REISCHAUER: Notwithstanding Chairman Putin's rulings here, there is free choice here. And some of these recommendations one through five, in my view, are more important than others. If one of the weaker ones went down, I would still be in favor of number seven. So I think we each have to balance this out. I don't think there's an obligation that these things are tied in the end here.

MR. HACKBARTH: So do you have a proposal?

DR. REISCHAUER: No, I'm not. What I'm saying is

that should one of these -- which I doubt they will -- not be approved, I don't think that still doesn't mean we shouldn't vote on number seven. That's what I'm saying.

MR. HACKBARTH: Okay, let's find out. Do you want to bet?

Put up one. We're going to do the votes now. Anyone opposed to recommendation one? Those in favor of recommendation one? Any abstentions?

Number two, recommendation number two. Opposed? In favor? Abstentions?

Number three. Opposed? In favor? Abstentions?

Number four. Opposed?

DR. SCANLON: I had suggested that maybe should be to the Congress, since the other defining recommendations were all that the Congress should either do something or ask the Secretary to do something. Given that this is so important, I would think that this is a congressional --

MR. HACKBARTH: Mark or Sarah?

DR. MILLER: I think it's the Congress would direct the Secretary to...

MR. HACKBARTH: With that modification, opposed? In favor? Abstentions?

Number five. There was also a minor word modification here.

MS. PODULKA: We moved -- at the very it says within three years. That's been moved up to dual eligible special needs plans within three years to contract.

MR. HACKBARTH: The Durenberger amendment.

All opposed? In favor? Abstentions?

Number six. Opposed? In favor? Abstentions?

And number seven. Opposed? In favor? Abstentions?

DR. REISCHAUER: Can I just make a comment on Bill's modification with respect to Congress? We're a bit worried that this might make the Secretary or CMS take them off the hook and say we'll wait for Congress to act. And that's often the kiss of death at this point.

Maybe in the text we could sort of say something about to the extent that the Secretary wants to move ahead, we would encourage this.

DR. SCANLON: I think that would be good. The Congress does have to act or the sun sets in 2008.

DR. REISCHAUER: [Inaudible.]

MR. HACKBARTH: Okay, now we've got about 20

minutes left to talk about the MA draft recommendation. Again, this is a draft and, Bruce, in just a second, will explain his thinking about this.

The goal for this discussion is to try to determine whether there is sufficient interest and support in this to invest time in trying to develop a final recommendation. Whether that would be for January or March or April I don't know. But it would be in this cycle this year. But this is not a final decision we're making here.

So Bruce, you can go first and then I have Jack and John and Jay and Nick.

DR. STUART: I'm delighted to see this and I guess what I'd really like to see is language here that was similar to the language on the Part D data release, which did two additional things. The first thing, it says why you want this, because I think that's important. And then the second is that it indicates that the data are going to be available not just to CMS but are going to be available to Federal agencies and Congressional support agencies. So I think that's important.

I think the other thing is that we have to recognize history here, and that this isn't something that

you could implement in the same fashion that you could with Part D because Part D has standardized language in terms of all of the way that the data are collected and CMS already has those data.

So I think those are the three things that I would raise. That's not to suggest that I have exact language in here. But I think those are things that we should consider in the next stage.

MR. HACKBARTH: Just a clarification about the process I have in mind. I wanted to make sure we had time to discuss this draft recommendation. I hope we're going to have a few minutes left at the end where people can ask questions about the MA update in general, the data that Scott has presented, et cetera. But I really want to try to get a sense of where we are on this draft recommendation. So let's focus on it for just a few minutes.

I have John and Jay, both of whom have experience with this issue. As Bruce well knows, this was discussed -- indeed hotly debated -- in the not too distant past as part of the risk adjustment discussion. And maybe if, John or Jay, you could just provide a brief bit of context, that would be helpful.

MR. BERTKO: Let me try to start. I'll let Jay speak for his organization.

But number one is, without due respect to Scott's statement, this is a bigger burden than he may have anticipated because for clinics and medical groups that specialize in this and are contracting to Medicare Advantage organizations, they don't collect this kind of data today generally. Even though they may have some subset that sends to fee-for-service, they may not have all of this. And recontracting and the new systems and the additional administrative costs are not insignificant. A typical actuarial double negative.

Secondly, there is already a data stream here that could be used better. I know Bruce might disagree with me about how significant it is, but the encounter data for risk adjustment is coming through today. It's a subset of all data, of course. My comment is that it's probably underused.

Now were we to say that should be made available to many other organizations, I would strongly agree with that because the data stream already exists and there is no additional burden whatsoever. But it is a subset of the

full data stream.

I guess at this point the third one is that while some parts of say the employer community may be modestly asking for more data, it's not an important part. And as far as I know, there are no plans in general across the industry to begin collecting more of this data. So this would be a substantial change to the way HMOs organize.

And the very last part is the other parts of MA, namely the PPO versions and private fee-for-service, do have the full data stream coming in. And were we to be -- I won't say satisfied -- but agreeable to use those parts of it, that is readily available. And if the recommendation were modified to say make those things available, then I'd be fully supportive of that.

MR. HACKBARTH: John, who is fully reporting data, private fee-for-service?

MR. BERTKO: Not so much reporting but collecting. What I'm saying here is the data mechanism collecting data for all the PPO plans and for the private fee-for-service plans is in place. And so to make the next point, the parallel to Part D for those plans is exactly there. The data is collected, it's available. It's not reported yet.

But you could say let's turn the switch and begin sending that data in and add the additional switch that says make it available to the selected agencies. That one has very little marginal cost.

DR. CROSSON: I won't reiterate the point. I think we have a balance of values here. It's hard to argue, in general, about collecting data. It's good to have data. I think the value of this for research purposes is real.

But that has to be balanced against the added cost. I think we noticed earlier today in the presentations that the most efficient plans, at least according to what was presented, are the HMO plans. At least one of the reasons for that is that this infrastructure that is required for claims collection is not necessary, at least for those plans who prepay to the delivery system. That is, of course, true of our organization.

Now I would acknowledge the truth, that this is probably going to change over time. And that is because the commercial world is exacting pressures on organizations like our own, through competitive pressures for self-funded arrangements and others, that will require the development of this capability over time. But it is not a capability

that exists at the present time.

So we always have a balance between the need for information and transparency and added cost. And I would just note that this situation is not unique. We've discussed before, and probably will again -- as it is in the current chapter -- the fact that there is an unbalanced playing field in Medicare in terms of the submission of quality information. And so we have not required quality information from fee-for-service Medicare because of the added cost and difficulty and because that information is often not collected by that part of the delivery system.

I think that needs also to be addressed, but it's only going to be addressed over time, I believe, with the development of clinical information technology. So I think my sense is that over a period of time both this problem that Bruce has identified and the other problem that I think is perhaps even more significant in terms of our stated goal to have a level playing field, will be addressed. But I think we should not add costs when it's not absolutely compelled.

MR. EBELER: While I think the balance Jay described is there, I would argue it's not just a research

interest. One of the difficulties here is that in making policy on MA, as well as in every other chapter we read, the absence of information on what is going on underneath the MA capitation rate is increasingly hobbling.

Scott, do we even know within MA what portion of the payments are distributed in the form of health benefits, the so-called loss ratio versus administrative costs?

DR. HARRISON: CMS has that data but we do not have it.

MR. EBELER: We don't know that?

DR. HARRISON: We do not have that.

MR. EBELER: But I'm saying we are sitting here, and so getting some stronger set of data about what's going on is not -- with all due respect to researchers -- it's not just a researcher's interest. We need that data in order to have researchers help fuel subsequent policy processes, as well.

And that level playing field on quality reporting, I think, is a good example. It's awkward but one has to move to it. And this might be an area where that's required.

DR. BORMAN: Just a comment and a question, and

they may both be incredibly naive. But it seems to me there is some parallel between defining what is encounter data and Bill Scanlon's comment earlier about defining what is a target population. And so that leads to my question.

I'm having trouble figuring out how one provides personnel and supplies and allots time in a clinic or other treatment facility without any kind of information about the nature of diseases being treated, the number of patients, and the kinds of services that are being delivered.

So in a sense of do we have CPT codes or do we have ICD codes or whatever for individuals in these prepaid less kaching at the visit systems, I absolutely accept that.

But surely there are some various kinds of data that might help start some sort of comparison or answer some sorts of the questions. Again, maybe a totally naive question, but...

MR. BERTKO: If I can answer part of your question at least, is that the risk adjustment data collection system that I referenced is the one that concentrates on what I'll call the big dollar items, the serious medical conditions. And so that one, over the last four years, has been set up. I would describe it I think in most organizations as working

pretty well today.

MR. HACKBARTH: You're asking information for whom? Who is the audience that you're worried about?

DR. BORMAN: We're asking here that we want plans to submit encounter data. And if I understand the proposition correctly, we're wanting to be able to rationalize based on comparing apples to apples that if we have encounter data we can say what an MA plan does or what a SNP does or what PFFS does based on counting the same things.

MR. HACKBARTH: Yes.

DR. BORMAN: I guess what I'm asking -- I interpret it, and maybe mistakenly so, the comments that we don't have traditional encounter data in a prepaid environment to be able to match up -- I heard the comment that we have data from the private fee-for-service analogy, but that's been collected but the analogous data or identical data are not collected in a capitated system.

So what I'm asking is surely there -- or maybe there are some proxies or something that hints at something similar to traditional encounter data that are from private fee-for-service. I, for one, can't see where having just

the private fee-for-service data are going to help us if our mission is to try and make a comparative value judgment if we don't have similar data from the MA plans. That's what I'm trying to get to.

DR. MILSTEIN: I very much agree with the portrayal of the pros and cons on this and variants of this discussion have come up over the years. At the end of the day we have to weigh the cost of supplementary data collection versus the cost of ignorance is basically what it boils down to.

As I think about how much we're paying for Medicare Advantage plans relative to fee-for-service, in terms of order of magnitude, it's hard for me to support the idea that the incremental data collection burden, to have a better idea of what we're getting for our money, does not represent good value.

So I agree with the framing but just in weighing the two, the pros and cons, I sort of come out in favor of incurring the acknowledged incremental cost of data collection and getting a better handle on what we're getting for our money.

I also very much support implicitly the point that

Jay made, that there needs to be balance here. When I was looking last month at our rather dismal statistics on whether or not our Medicare Advantage plans are actually impacting beneficiaries' ability to function in life, the so-called health outcomes survey, it bothered me that a decision was made within Medicare by an unknown person five or six years ago to stop collecting that data for Medicare fee-for-service.

Granted, the numbers on the Medicare Advantage side may have been disappointing. How are we doing on the fee-for-service side on those same statistic?? I support this and would actually support, either now or at some other point in our deliberation that Glenn might identify, and encourage the discussion to widen to better information on both the fee-for-service and the Medicare Advantage side.

And for that matter, also widening the parties that have access to the information. Periodically at this Commission -- and it's been on the New York Times editorial page -- we haven't quite engaged on it, is this problem. In our reports we say if you want to encourage improved efficiency and quality of the American delivery system, we've got to think about ways of creating more synergy

between the private sector purchasers and Medicare. We have a split system.

And one of the ways that this could happen would be through much better information sharing between the two sectors, obviously subject to whatever is necessary to protect beneficiary privacy.

DR. WOLTER: This is more a general comment and I certainly don't consider myself an expert in this area, but Scott and Jennifer, I thought you did a wonderful job packaging up what's really a pretty complicated analysis and a great package of recommendations.

One thing I particularly liked was the framework that we went back to and reviewed in terms of some of our previous thinking about MA because I think it is a good thing for the Commission to set some framework and then come back to it and stay persistent as we go through the years in complicated changing political times.

In that regard, to go back maybe to the ghosts of MedPAC past, one of the things I'm a little bit concerned about, as some of you know who have been on the Commission as long as I have, is any implication that the fee-for-service system is efficient. I worry about that because if

we MA to be at least as efficient as fee-for-service, that's a very low bar in some parts of the country.

And coming from a rural area, I'm very, very concerned because I couldn't agree more that we've got to get control of this MA explosion. And if we're going to do value-based purchasing in fee-for-service, we better try to do it in MA as well. So what does that mean? And how do we try to move sort of the payments in some equitable way together?

From a rural area, I'm concerned that if county level fee-for-service is the equivalency, we're going to have two geographically inequitable payment systems if we don't thoughtfully think about how payment designs might evolve to address the problems that we're all, I think, recognizing are present.

I've made that point in the past and just wanted to have a chance to do it again.

MR. HACKBARTH: There clearly are issues, as you say, in the fee-for-service system about equity and efficiency. In fact, I've got now I don't how many shelves of red books that thoroughly document that we don't think the fee-for-service system is efficient or necessarily

equitable in all cases. So I agree with that.

Bob, did you have a comment?

DR. REISCHAUER: Yes, just a comment on this from sort of 30,000 feet. It would be why, in the best of all worlds, do we really care about encounter data at all? What we really worry about is initial conditions, diagnoses, risks entering, and outcomes at the other end.

And to look at what the encounters are when we don't have a strong evidence base that the various services provided have positive value or strongly positive value, and then to say well, in Medicare Advantage they're doing only two-thirds of what fee-for-service is doing, which we don't have any idea whether it's doing good or neutral, strikes me as sort of a strange kind of set of demands. That what it could do is sort of fuel an effort to get -- I think what Nick is suggesting -- Medicare Advantage to look more like fee-for-service, which we know is inefficient.

MR. HACKBARTH: Okay, are there any questions or comments about the MA update that Scott has presented?

MR. EBELER: Scott, maybe if you could go back to the table benchmarks, bids and payments, just to make sure we get the trends here because they strike me as a little

troubling.

The key item, to me, is always the bid versus fee-for-service, the comparative efficiency. It's not on here but as I understand it that's gone up from last year, on average?

DR. HARRISON: For 2006, we had the average at 99 percent. One of the reasons could be larger -- this is all enrollment weighted. So we had much lower private fee-for-service enrollment back then.

MR. EBELER: That's another trend we can get to but we still have HMOs below the benchmark. The payment trend also, the 112 to 113, is what one would regard as a negative direction, again because of enrollment weighting.

MR. HACKBARTH: Could I just go back to the bids for a second, Jack? So the average bid now is, for all plan types, is 101, HMO is 99. My recollection was HMOs were 97; is that right?

DR. HARRISON: Yes, I believe they were 97.

MR. HACKBARTH: So the HMOs themselves have gone up relative to fee-for-service.

MR. EBELER: The last meeting we learned that quality trends aren't positive, shall we say, and if

anything are negative. We're not doing it here but in the chapter we also learned that a number of plans are not even reporting on the required quality measures I think is what is implied there.

It seems to me that the fourth trend here, if you flip back to the growth chart, the growth in the program is among all of the plans that do worse on all of these indicators, which is somewhat of a tautology because that's what's driving the indicators wrong. But we are seeing growth in the plans whose bids are worse compared to the benchmark and who either don't report quality measures at all -- private fee-for-service plans or -- so they're not even in here. So that sort of sits out there.

It seems to me, and Nick reflected on this, the base set of recommendations from prior years are all the more important. I think a lot of us would be happy to pay more if we got better quality. But that trade off isn't occurring.

I guess my only comment is we think about the next presentation. I know we're not getting in here. But it strikes me that the Commission needs to say as clearly as we can that we really have to question the sustainability of

this program as it is evolving in the absence of relatively rapid adoption of our recommendations because you are really posing a fundamental risk to Medicare here.

It seems to me the question for today is to make sure we get the trends right. They don't look good as I look at these data.

DR. CROSSON: Something of a nit here, but in the text the charts on the quality issues on page 26 and 27, I think could be improved a little bit in terms of clarity. And I think I mentioned this to several people. So in some parts of the chart, words are used. And in other parts little crosses are used. I think it would make more sense -- it's not going to change the somewhat disappointing results, but I think it will be a little clearer if it said worse/better or plus/minus or yes/no as opposed to the way it is.

MR. HACKBARTH: Fair enough.

Could I go back to the issue that Jack has raised about the trends? Could you put up the slide that has the employer -- yes, that one.

Anecdotally, I have heard that there are lot of employers working with their plans that are now focused on

this employer-only opportunity. And this might be the next stage of growth. What do you know about that, Scott? And then John and others who are knowledgeable.

DR. HARRISON: From the data we have, we can't always tell because an employer doesn't have to go through an employer-only plan. They can enroll their members in plans that are open to everybody. But what we know is right now, in the employer-only plans, there are 1.3 million enrollees and about 30 percent of them are now private fee-for-service.

I do know that that has changed in the last year. The percentage that is private fee-for-service used to be much smaller.

MR. HACKBARTH: The potential that's concerning to me is that because this is not retail when you talk about the employer-only plans, there's the potential if this really catches on, for big blocks beneficiaries to be converted to much higher level of payment, as evidenced by where the bids and payments are right now. And obviously, it's going to be done selectively and the employers that go into it are going to be the ones where the payment rules are most generous for us and then they're moving not one and two

and three beneficiaries at a time but hundreds, if not thousands. That seems to me to create alarming possibilities.

MR. BERTKO: Let me add a couple of things. I was going to mention this to Scott outside the session. But number one here is on the employer-only ones, as opposed to the straight, I'll call it community rated part, these are most typically experience rated. I have some experience but not huge experience in this.

There is a combination of two things going on. One is many of these retiree plans come from what you might call smokestack industries. And the risk adjustment system for them may not work well enough in the sense that they are at the upper end of the risk spectrum.

MR. HACKBARTH: [Inaudible.]

MR. BERTKO: Not deter employers. But when they come in, the bid is higher to compensate for it. And I have personal experience with one particular smokestack industry company -- very large -- that had Medicare fee-for-service data, because we actually could see that, that was nearly 200 percent of the average community -- what used to be the AAC PPO, the rate book.

And so Glenn, your worry here is -- I won't say misplaced, but different when you would actually move very high cost class people out of fee-for-service into Medicare Advantage, it's really one pocket to another as opposed to as much of a worry about the overpayment thing that you're worried about.

The second part of that comment is somehow some part of that is mixed in with induced demand much in the way that Medigap and some of our other studies have shown that. So the demand from these folks who have had traditionally very rich prescription drug benefits and mostly pretty rich benefit structures through the retiree benefit system have -- again in my limited experience in this -- very much higher usage and utilization in Medicare fee-for-service.

So the situation is probably not as bad as you look at. It's worth concern. But the 116 is not so much a plan reaction as is, I'll call it, a plan protection through the experience rating device of looking at the actual two or three years of experience on fee-for-service before they transitioned to Medicare Advantage.

MR. HACKBARTH: So let me play it back, John, just to make sure I understand. What you're saying is okay, we

have a payment structure where the base payments before risk adjustment can be very high, particularly in certain parts of the country, relative to Medicare fee-for-service costs. And that seems inviting. On the other hand, some of the big groups in the smokestack industries are high risk groups and the Medicare risk adjustment system made undercompensate for their actual risk. And that may deter these large groups from going into this, even if the base level payment is high because they're going to lose in the risk adjustment game.

MR. BERTKO: And a further implication of this is that because these are experience rated, a company offering these as an MA company could actually see ahead of time the historic experience and thus write the bid upwards. But it's not only that they're in high payments but that the actual experience well exceeds the rate book payment for these particular smokestack industries through a combination of both higher risk not measurable and the induced demand part of it akin to the Medigap side.

MR. HACKBARTH: Other comments, questions?

Hearing none, thank you very much.

We'll now have a brief public comment period before lunch. As usual, I'd ask commenters to first

identify themselves; and second, to keep your comment to no more than a minute or two.

For the benefit of people who are new to MedPAC, we try to have a brief public comment period. I recognize that it's not nearly liberal enough for some people. I would simply emphasize that the staff go to extraordinary lengths to try to reach out to people and understand different perspectives. And I urge anybody interested in MedPAC's business to use that as their way to communicate with the Commission and get us necessary information. Don't think of the public comment period as being your only or even your principal opportunity.

With that preface...

MS. HSIAO: My name is Katharine Hsiao and I'm an attorney at the National Senior Citizens Law Center. Our team based in -- we are a national organization, but my group based in Oakland, California has been working solely on low-income beneficiary issues related to Medicare Part D since mid-2005.

I wanted to just commend the Commission and its staff for its great work and particularly for your concern for low-income beneficiaries and for dual eligibles who

really continue to be adversely impacted by the transitions that have occurred for them.

At this time of year, we are, of course, very concerned about the 2.5 million that Ms. Schmidt referred to, which is the combination of the people being reassigned within a plan or to a new plan, and also the people who chose a new plan but would have been reassigned if they hadn't done that that are all facing a more than zero premium as of January of next year if they don't change plans. That's a very huge group. We appreciate that you're looking at the transition policies.

We wanted to also suggest you look at publicizing transition policies, requiring plans to make available to beneficiaries knowledge of the right to transition if they get in a glitch and they aren't able to access a prescription drug they need because they're in a new plan. And the importance of letting beneficiaries know their rights in that is very, very important, particularly as you has these large number of people changing plans.

In addition to that, a major advocacy emphasis for us within the context of low-income beneficiaries has been language access and that many, many, many of the low-income

and vulnerable elderly and individuals with disabilities have limited English proficiency. In California, we facilitate a California Medicare Part D Language Access Coalition. Earlier this year we published a study "Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries."

Thirty percent of dual eligibles in California, which is 300,000 people, are limited English proficient. These individuals, it's totally confusing to any Medicare Part D beneficiary, all the changes that are happening, all the advertising they get, the notices they get from different state and private plans. But if you're limited English proficient, it's really impossible.

We did this study. We found out that 60 percent of the calls that we made in a statistical survey could not get to a speaker in their own language even though that is required of plans. We talked to CMS about it. They urged us to come out with some best practices for how the plans should be relating to these populations and we have that. And I want to share that information with the Commission.

In addition to do, we have quite a bit of information on what we think are the key issues affecting

dual eligibles, the gaps that remain, the protections that still need to be put in place or enforced to really protect this vulnerable population. A lot of that's available on our website but I did want to present it to you.

Again, thank you for your work.

MR. HACKBARTH: Okay, we will adjourn for lunch and reconvene at 1:30.

[Whereupon, at 12:29 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:37 p.m.]

MR. HACKBARTH: For the remainder of today and tomorrow morning we are discussing payment adequacy, beginning with hospitals. So Jack, are you leading the way?

MR. ASHBY: Yes, indeed.

Good afternoon to everyone. This session will address payment adequacy for hospitals leading up to update recommendations for both acute inpatient and outpatient services. You will remember that we assessed the adequacy of current payments for all services that hospitals provide to Medicare beneficiaries together, and that includes inpatient psych and rehab, SNF, home health, and graduate medical education, in addition to the inpatient and outpatient.

Before I start I'd like to take just a moment to thank several people who contributed in a major way to the analyses we are going to be presenting on today. That includes Tim Greene, Craig Lisk, Dan Zabinski, Julian Pettengill, and David Glass.

Each year the Commission makes a judgment on the adequacy of payments in the current year, which is fiscal year 2008 this year after examining information on the six

factors that you see listed here, ending with payments and costs for 2008 expressed as a margin.

In addition, the MMA requires us to consider the efficient provision of services in recommending updates. One of the ways that we do this is to generally require that providers improve their productivity by a modest amount each year while maintaining quality. The Commission's approach is to set a target for productivity improvement based on the 10-year average growth of total factor productivity in the general economy. That stands currently at 1.5 percent.

Starting with access to care, we first look at the share of hospitals offering certain services. We've monitored a set of 10 specialized services since 1998 and we found that the share of hospitals offering nine of the 10 has risen over that time, including some sizable increases in 2005. The share of hospitals offering outpatient services, including emergency services, has been stable since the outpatient PPS was implemented in 2001.

Then we monitor the number of hospital openings and closings. Each year since 2002 more hospitals have opened than closed and the annual number of closures has dropped from almost 100 in 1999 to only 16 in 2006.

A large number of hospitals have also converted to critical access hospitals, over 1,100, over the last seven years. Another 72 hospitals have converted to long-term care hospitals during that time.

Turning to the volume of Medicare services, growth in outpatient services per fee-for-service beneficiary has been quite strong but the rate of increase has fallen from about 9 percent in 2002 to about 2.5 percent the last three years. Inpatient discharges per beneficiary have grown more slowly, averaging about 0.5 percent per year.

In the area of quality, we have three analyses that, taken together, support the conclusion that quality is generally improving. First, mortality has declined in all of the conditions measured over the last eight years. Second, performance in delivering recommended care to beneficiaries improved on almost all of the measures, 22 of the 23 as you see here, in the first two years that these data have been available on the CMS Hospital Compare website.

And finally, patient safety results have been mixed. The rate of adverse events increased -- that is, it has gotten worse -- in five of the nine most common

measures.

On access to capital, the most direct indicator of hospitals access is the level of their actual capital expenditures. As we see in this graph, hospital construction has increased steadily, doubling in inflation adjusted form between 1999 and 2007. The largest increases, averaging about 20 percent, have come in the last two years.

And then, as Jeff reported at the last meeting, we also found that the value of construction permits per capita -- also inflation-adjusted -- has reached the highest level since 1969 when the industry's first construction boom was fueled by the Hill-Burton program and enactment of Medicare and Medicaid.

In addition to construction spending, the growth in tax exempt bond issuances has been strong and the value of debt for hospitals with upgraded credit ratings far exceeds the value of hospitals with downgraded ratings. The median value of several financial indicators -- these are things like days cash on hand and measures of debt service coverage -- are, for the second year in a row, among the best ever recorded.

And finally, a recent survey indicated that 84

percent of nonprofit hospitals plan to add capacity in the next two years, implying that they expect to continue having access to capital.

Turning to financial performance, our first chart here presents Medicare margins through 2006. The margin was unchanged at minus 3 percent going from 2004 to 2005 but then declined to minus 4.8 percent in 2006. The sizable drop in 2006 doesn't really represent a trend. We simply had policy changes that increased payments in 2005 and we had policy changes that decreased payments in 2006.

Looking at our two component margins, the gap between the inpatient and the outpatient margin has narrowed to about 8 percentage points in 2006. As recently as 2002 this gap stood at 15 percentage points. This change is due primarily to lower outpatient cost growth over the last several years.

The next slide shows our 2006 overall Medicare margins by hospital group. The rural margin is a little lower than the urban one, after having been a little higher in 2005. And that turnaround is due to higher cost growth for rural hospitals. Of course, we have another almost 1,300 rural hospitals in the critical access hospital

program and these hospitals are paid 1 percent above costs for both inpatient and outpatient care.

The group with the poorest financial performance once again is non-teaching hospitals at minus 8.5 percent.

Our projection for 2008 is minus 4.5 percent, an improvement of three-tenths over 2006. This projection captures the impact of policy changes affecting inpatient, outpatient, and hospital-based post-acute care services in 2007, 2008 and 2009 together with an assumption about cost growth that I'll explain in a moment. So the projection represents our best estimate of what margins would be in 2008 if 2009 policies -- other than the update we're here to talk about -- applied at the time.

In general terms four key factors lie behind this projection. First is that we foresee a continuing trend of cost growth exceeding the forecasted increase in the hospital market basket. The combined rate of increase in inpatient costs per discharge and outpatient costs per service fell slightly in 2005 and then fell a bit again in 2006, but evidence from a Bureau of the Census survey and data we have available to us from six for-profit chains suggests that the rate of cost growth is edging up again in

2007 and we assume that somewhat higher rate of cost growth in doing our projection.

The second factor is reductions in payment from a cut in capital payments and the scheduled end of a special geographic reclassification system that came in in MMA.

Next is three payment increasers that more than offset the previous decreasers. First is a legislated payment increase for Medicare-dependent hospitals. Second, our simulations suggest that fewer hospitals will be affected by the post-acute transfer policy under MS-DRGs relative to the current CMS DRGs. And third, disproportionate share payments will increase due to rising low-income share values.

The last factor is that we expect the increases in payment resulting from changes in coding practices and medical records documentation following the introduction of MS-DRGs to exceed the legislated coding offsets which are 0.6 percent in 2008 and 0.9 percent in 2009. You'll recall that CMS, when it first introduced the MS-DRG system, estimated that coding and medical records changes would increase payments by 2.4 percent a year. And that was based on Maryland's experience in implementing APR-DRGs. We did

our own analysis and recommended a middle ground coding adjustment of 1.7 percent a year. That's about one-third less than what's CMS had come up with.

No one can definitively predict the size of the coding and medical records changes but at least three factors strongly suggest that the effect will be larger than the legislated coding adjustments. One is the experience of Maryland hospitals, which clearly points to a larger effect, particularly for teaching hospitals. Another is that the documented coding effect has been larger than originally estimated virtually every time that CMS has dealt with this type of change, and there have been several situations somewhat analogous to this one.

And third is the changes in complication and comorbidity, or CC, definitions that CMS implemented together with the MS-DRG system. These change the information required to qualify a patient as having a CC, and therefore potentially qualifying for a higher payment. These changes in definition well likely elicit perfectly legitimate coding refinements from hospitals that, in turn, will increase payments.

Congestive heart failure provides an excellent

example of the effect that changing CC definitions can have. CHF is one of the most common secondary diagnoses in the Medicare population. In 2005 it was coded as a secondary in 2.2 million cases. That's almost one in five inpatient payments nationwide.

Under the old DRG system, simply coding CHF not otherwise specified qualified CHF as a CC. In other words, any and all cases with CHF as a secondary diagnosis could qualify for higher payment in the few instances that the DRG system recognized severity differences at the time.

Now under the MS-DRG system, CHF not otherwise specified is no longer good enough. One of 13 specific types of CHF must be coded in order for the case to qualify as a CC, and therefore to be certain of receiving higher payment.

In 2005, 93 percent of the cases coded with CHF as a secondary would not have qualified as a CC under the new system. The unknown is how many of these patients actually had one of the 13 types of CHF but the physician didn't record the necessary information in the medical record or the coder didn't pick up the detail simply because there was no particular reason to at the time. Medicare wasn't asking

for this information. In the future, hospitals will have a strong incentive to make sure that the more specific codes are used whenever the patient's condition warrants it.

As we've shown in past years, the ratio of payments to costs in the private sector over time shows the three distinct periods that we can see on this graph. We have viewed the private payer payment-to-cost ratio as an indicator of financial pressure. When private payer payments are falling relative to costs -- that is when financial pressure is high -- then the industry's rate of cost growth has been below market basket. That's what we observed in the 1990s. When private payer payments are rising faster than costs -- as has been the case since 2000 -- it generates the funds needed to support a rate of cost growth that is above market basket.

The interesting thing though is that the private payer payment-to-cost ratio has begun to flatten out over the last two years, which may indicate that private payers are beginning to toughen in their negotiations with hospitals. But simultaneously, hospitals' so-called other operating revenue has increased. It increased by 17 percent in 2006 and that helped support a higher rate of cost growth

the same as additional revenue from private payer payments. We don't really know what lies behind the 17 percent increase but we suspect that one of the key factors is income coming in from joint ventures with physicians and other provider groups.

Now Jeff is going to explore this relationship between financial pressure and cost growth for individual hospitals.

DR. STENSLAND: Jack talked about the average financial pressure faced by hospitals across time. Now I'm going to examine financial pressure at the individual hospital level and talk about how that can affect hospital costs.

The end result is we find the same thing: high financial pressure leads to lower cost. In this slide, we divide hospitals into three levels of financial pressure: high, medium, and low. We define a hospital as being under a high level of financial pressure if it meets two criteria. First, all high pressure hospitals had a median non-Medicare profit margin of 1 percent or less from 2001 to 2005. In other words, the average profit on privately insured, uninsured, and other non-Medicare sources of revenue

generated at most a 1 percent margin.

Second, none of the high pressure hospitals had their net worth -- meaning their assets minus their liabilities -- grow at more than 1 percent per year from 2001 to 2005 due to non-Medicare revenues. We need to also look at net worth in addition to income statements because some hospitals may have large unrealized investment gains or donations for buildings that are not recorded on their income statement that will affect their net worth. For example, if a hospital is just breaking even, it may not feel that it's under financial pressure if it had just received $100 million in donations under a capital campaign for a new building.

In sum, we are roughly saying that hospitals with margins less than 1 percent and stagnant or declining levels of net worth will feel financial pressure to constrain their costs. As a table shows, hospitals that are under high levels of financial pressure have costs of $5,500 per discharge on average. That's standardized costs. In contrast, hospitals with low levels of financial pressure have costs that were over 10 percent higher, at $6,200 per discharge. These differences in costs lead to large

differences in Medicare margins. Again, the message is pressure constrains costs.

In this next slide we shift gears a little bit. Rather than looking at different levels of financial pressure, we divide all of the hospitals in our sample into three groups based on their cost. We have roughly one-third of hospitals that have standardized costs below $5,600 per discharge -- this is the first column, the low-cost hospitals -- while one-third have costs that are above $6,300 per discharge. These are the high-cost hospitals in the last column.

Among the low-cost hospitals there's a 5.1 percent overall Medicare margin with 71 percent of the hospitals with low inpatient cost having positive Medicare margins. In contrast, high cost hospitals had an overall Medicare margin of negative 15.6 percent. You see the different in costs driving a difference in margins.

While it's not shown on this slide, roughly 22 percent of hospitals have consistently had high cost for the last three years in a row. As we discussed last year, if you remove these consistently high cost hospitals from the Medicare margin calculation, the average Medicare margin

would rise by roughly 3 percentage points to a negative 1.7 percent.

The next question that might arise is are these hospitals with low cost able to deliver high quality care? Some low-cost hospitals have below average quality scores and some high-cost hospitals have above average quality scores. In this past year we decided to make some site visits to some hospitals that consistently had low costs per discharge and that consistently ranked above average on the Medicare Compare website, as well as at least one outside ranker of hospitals, such as HealthGrades. We wanted to examine the common characteristics of these low-cost high-quality hospitals.

There were at least two factors that set these hospitals apart from others that we visited over the years. One is evidence of strong physician commitment to the hospital and the second is the staff's strong focus on quality metrics. I guess the lesson and the point I'm trying to get at is that we do have examples of hospitals that have been able to achieve the combination of good physician relationships, low-cost, and high quality scores.

Now Jack will discuss the draft recommendation.

MR. ASHBY: Okay, to start the conversation on updates, we've put up the same recommendation the Commission made last year.

The Congress should increase payment for the inpatient and outpatient PPSs in 2009 by the projected rate of increase in the hospital market basket, concurrent with implementation of a quality incentive program.

This recommendation might represent an appropriate balancing of our findings for this year, as well. On the one hand, we have positive outcomes in our assessment of payment adequacy with access to care appearing stable, volume of services continuing to increase, quality of care generally improving, and access to capital maintaining the new highs reached last year.

On the other hand, while hospitals' margins under Medicare are not expected to drop through 2008, they will remain low, which is cause for concern.

In our recommendation last year, we included the important notion that a full market basket should be implemented together with a quality incentive program. Although P4P would operate separately from the update, hospitals' quality performance would then determine whether

their net increase in payment is above or below market basket increase.

CMS has recently signaled its readiness to implement P4P for hospitals in 2009 if Congress authorizes it, and so we may want to add this provision to our recommendation again this year.

The update in law is full market basket and so this recommendation would not have any budget implications and we expect no major implications for beneficiaries and providers.

Our second recommendation from last year was a budget neutral reduction in the indirect medical education adjustment.

The Congress should reduce the indirect medical education adjustment in 2009 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the IME adjustment should be used to fund a quality incentive program.

The Commission further recommended last year that funds from reducing the IME adjustment should be used as a part of the financing for quality incentive. If we, for example, had a 2 percent pool for P4P, the reduction in IME

would fund about half of that pool. Our rationale for this recommendation still certainly implies and that is that the IME adjustment rate is set considerably above the measured relationship between teaching and hospital costs, which contributes to the large differences in Medicare margin between teaching and non-teaching hospitals that we saw several slides back, and that teaching hospitals will benefit in the coming year from implementation of severity adjusted DRGs.

This recommendation would also have no budget implications and we expect no major implications for beneficiaries and providers, although it would reduce payments to teaching hospitals and increase payments for non-teaching hospitals.

That's our presentation and we'll open it up for discussion.

MR. HACKBARTH: Thank you, Jack and Jeff.

Before we start the discussion, let me just say a word for the audience about the draft recommendations. For each of the provider groups: hospitals, physicians, home health agencies and so on, as we move through the presentations today and tomorrow there will be draft

recommendations. In each case the draft recommendation is what we recommended last year for the same provider group.

Having briefly reviewed the updated information, it seemed to me that we were, in almost all cases, in a pretty similar position in terms of financial performance and access and quality information as we were last year. So it seemed that last year's recommendations were a reasonable starting point. But I would underline only a starting point. We're free to, of course, change those based on the discussion that occurs.

So let's open up the discussion.

MR. EBELER: Thank you for the presentation. A couple of questions, maybe if you go to chart 18 it would help frame it.

As I understand it, one of our criteria is whether or not an efficiently and economically operated institution can do well under the payment policy. Is that one of the new criteria?

So that's one of the criteria, apparently, we're supposed to look at. Am I to read this chart as one way of analyzing whether there's some degree of confidence that a cohort of hospitals does seem to be able to have positive

Medicare margins under current payment policy?

MR. ASHBY: Certainly that would be -- yes, that would be a scenario.

MR. EBELER: In the recommendation of a market basket increase -- and I understand that's just a placeholder at this point -- where does that take into account the piece you mentioned in the paper -- I don't think you included it here -- of a 1.5 percentage point productivity improvement?

MR. ASHBY: It would not. That's our general model, is to make an adjustment for productivity. In this case, we were balancing the positive findings on the adequacy of payments with the low margin operation and essentially coming to the conclusion that we would not invoke the productivity adjustment this time. That's an open question, of course.

MR. EBELER: The question I would pose for future discussion is whether the situation has changed enough that one could say this year we could invoke that, given what we're seeing about -- whether it's a full adjustment, but something less than market basket, whether that should be something we at least discuss.

MR. HACKBARTH: Let me just pick up with slide 18. This isn't the full universe of hospitals, or is it the full universe of PPS hospitals divided into three parts?

DR. STENSLAND: Yes, every one we had full data on that had filed a timely cost report.

MR. HACKBARTH: So this is the universe of PPS Medicare hospitals divided into thirds. It basically shows if you have high costs you have low margins. Not exactly headline worthy. But perhaps the more important not so obvious messages is that there's a tremendous range in financial performance within the Medicare program.

Last year you had presented data a little bit different analysis than this where you compared institutions to their peers in the same market, which interested me in the sense that it said okay, within a given market there are winners and losers. And there were some common characteristics among the losers, namely they tended to have not just higher average Medicare costs -- which of course is part of being a loser -- but they also have lower occupancy rates, et cetera, information that indicated that they were less efficiently performing hospitals than their peers within the same market place. Have you redone any of that

analysis? And why aren't we seeing that?

DR. STENSLAND: We do that analysis. We didn't put it in a slide but I can go over it quickly for you.

Essentially, we looked at the hospitals again that were consistently high cost. While there's one-third of them that were high cost in 2006, there's 22 percent that had been consistently high cost over three years. So we took a look at those hospitals. And their standardized cost was almost $7,000 per discharge. And then we looked at the neighboring hospitals that were within 15 miles. And then you get down to about $6,200 per discharge.

So in the great generality, these consistently high-cost hospitals had costs that were roughly 10 percent higher than their competing neighbors and correspondingly lower margins. They also tended to have a little lower occupancy. And they also tended to be hospitals that had a little lower decrease in Medicare length of stay over time.

So this combination of a little lower occupancy, a little lower decrease in length of stay over time, and whatever factors are there resulted in them having usually high costs compared to their competitors.

DR. MILLER: The reason things are, I think, a

little different is that analysis is there. But it was sort of 17 and 18 where I think what Jeff was trying to do was get at this efficiency question in a couple of different ways, the fiscal pressure argument and then the more straight, let's just slide it by cost argument.

DR. STENSLAND: The new thing this year was the fiscal pressure because we wanted to say let's separate out the timetable. Let's say if you were under financial pressure from 2001 to 2005 and essentially the idea then is the board sits around the table and says we have to keep our costs under control because we're not making much money, our net worth isn't increasing very fast. What would happen in 2006? That's kind of the new analysis, the financial pressure connected to the costs.

We see it's very consistent with this, that when you're under financial pressure in the first five years the following year you tend to constrain your costs.

DR. REISCHAUER: Just on this same chart, did you calculate for these three categories the fraction of their business that was non-Medicare/non-Medicaid? In other words, private pay?

DR. STENSLAND: We did for the financial pressure

and I remember there wasn't that much of a difference between the Medicare shares. A little bit of difference, you're under a little bit more pressure depending on your Medicaid share. But it wasn't that dramatically different on Medicare and Medicaid. We don't have good data on uninsured so we don't have that. We can't separate out our private insured versus the uninsured, which is an important separation. We just don't have good data on that.

DR. KANE: On the second recommendation from last year -- I have two questions. One of them is I can't remember what actually has happened with the IME? Did it not change? Or did it come down by a -- I can't remember.

MR. ASHBY: In terms of the policy, it went up for 2008 after having gone down in 2007. It's hard to understand that. But it is now at 5.5, which is roughly the same day we were looking at when we started that period.

MR. HACKBARTH: It went up as a result of a long-term policy. Congress had put in the statute a series of changes in the IME adjustment. There wasn't new legislative action last year to increase it.

MR. ASHBY: Right, it was just the last year of a series.

MR. HACKBARTH: The last year of the series already set in law.

MR. ASHBY: And now it has hit 5.5, which they intended to be the long-term rate.

DR. KANE: Because we thought still there was some point at which it was empirically justified but it was about what, 2.5?

MR. ASHBY: Roughly 60 percent of the payment can be considered subsidy and 40 percent empirically justified.

DR. KANE: And the other question I had -- well, I have a couple questions.

On 17, when you're showing Medicare costs per discharge, or 18. If everyone got down to $5,500 standardized Medicare costs per discharge, is there enough revenue in the system for everybody to make a break even or a profit? Or is there something going on?

MR. ASHBY: If everybody operated at that cost level, there would be enough money in the system for everybody to be operating at a profit, a positive margin.

DR. KANE: So it's not driven at all by geographic area or whether they get a lot of DSH? This is all standardized cost. But if everybody operated at that

standardized cost, would they still make a profit? Or would they not because of the geographic adjustment factor or the DSH?

MR. ASHBY: Those factors would determine how it plays out geographically. It would not be equivalent across every hospital. But in the aggregate, yes, if everybody operated at that cost level then the industry as a whole would have a positive margin, if not all institutions.

DR. STENSLAND: There may be a couple institutions maybe if they feel -- the wage index isn't exactly right for every area, as we've talked about before. And maybe if you're in an area where we think you're getting a particularly poor wage index, you still might have a little problem.

Another point to note is these are inpatient costs. So they would still expect, if they got $5,500, basically almost everybody making some inpatient profit. But not necessarily everybody would have an overall profit depending on what other services they have, SNFs and outpatient and that kind of thing.

MR. ASHBY: And we should still add that the differences between teaching and non-teaching hospitals

would still be there.

DR. KANE: Okay.

DR. CASTELLANOS: Good job, and I really appreciate that.

Jeff, you gave an example of low cost, high quality, and you mentioned some common characteristics. You mentioned good physician relationships. I wondered how you measured that or how you recognized that? What's the difference between relationships in the high quality and high cost? And what is it with the physician communities? Is there an ownership issue here or something to that?

I have another question beside that, too.

DR. STENSLAND: We've gone on different site visits for different purposes and on these site visits we tried to compare how do they discuss the physician relationships. And the physician who came in to talk to us, how did they discuss a hospital differently from other areas?

In some cases, we talked to some physicians and they seem almost, in some communities, indifferent to what's going on in the hospital. In this case, we heard things such as -- well, in the one case the physicians were very

involved. This was an integrated system. So they were involved in creating an electronic medical record to track quality and check on whether they were getting aspirin for the AMI patients when they came in. And not only whether the hospital was doing but whether the ambulance driver had done it before, so they get credit for that. So physicians being involved in that.

Another simple example is at another site visit whether the physicians weren't integrated, they were independent practitioners. But they had come all under a common electronic medical record. And they would say things to us such as what's good for the hospital is good for me, that kind of a mentality which we often didn't here in some other communities.

MR. ASHBY: I would add an example that I happened to be involved in on a site visit of tremendous physician involvement in implementing protocols for treatment of chronic conditions, a team with a physician involved in a review of every patient. Just the level of involvement and enthusiasm among those physicians was -- you just couldn't miss it in talking to them.

DR. CASTELLANOS: I guess the question was how do

we motivate that? If we can do it in that set, how can we motivate it all over?

MR. HACKBARTH: That's one of the reasons we're exploring bundling is as a potential policy or virtual bundling. The idea is to, through our payment policy, create the reality that physicians and hospitals are in this together as opposed to just operating independent of one another. The ones who do it best will fare well and be rewarded under those policies.

DR. CASTELLANOS: You also mentioned integrated system, which is really important.

The other question I have is on draft recommendation two, when we you talk about IME. We did talk a little bit about the workforce problem last year. As you know, with the medical schools they've increased -- I think there's eight or nine of them that are being developed this year. We've increased that population. But we certainly have not increased the specialty training programs, especially with the baby boomers coming and the baby boomer who are doctors retiring, there's going to be a loss of specialist. I'm just wondering if this is going to send the wrong message to these training programs.

MR. ASHBY: Keep in mind, first, that this is the indirect medical education adjustment. This is not changes to GME, which directly funds their education program. This is meant to cover the additional costs of patient care that come with operating as a teaching institution.

And our analysis fully accounts for the affect of those teaching programs on patient care. So if we had it at the empirical level, we would be providing the payment that corresponds to the actual costs that are incurred.

DR. CASTELLANOS: It was my understanding this IME monies went to the program chairman and there was very little, if any, justification of how that was spent.

MR. ASHBY: No, it generally does not. It goes to the hospital.

MR. HACKBARTH: The checks are cut to the hospital and then how the money is distributed varies, I assume, widely among institutions. It's a matter of institutional policy at that point. They could, if they wish, give it to the chairman. Or the board could keep it for non-medical education related purposes, for example to help finance uncompensated care.

In talking to the institutions about that money is

spent, you hear a lot of different activities that it's spent on. So there is not a uniform approach to its distribution.

DR. WOLTER: I was going to say we could insert my comments from the last few years and it would save a lot of time. But just a couple of points.

It's obviously very interesting information. It is a little concerning that the high pressure hospitals that have the positive Medicare margins have stagnating or declining net worth. In the past -- I think I heard you say that.

DR. STENSLAND: Let me clarify. I tried to make things a little simplifying, but I said their net worth would have been stagnant or growing at less than 1 percent a year if it wasn't for their Medicare profits. So if their net worth grew by $1 million and $750,000 of that was Medicare profits, then I would have recomputed that as only a $250,000 net worth gain, exclusive of the profit they made on Medicare.

DR. WOLTER: I was just starting off with that to kind of make the point that it seems like there's lots of other characteristics here it would be nice to understand,

to really understand this story. I don't know which of these three categories might have low percentages of Medicare books of business compared to high percentages. You don't know where management -- the ability to be a little bit more lax from a management standpoint fits in to strategically you're in a good position because of strong commercial payment to do certain things and you have a low Medicare mix anyway. I mean different things might feed motivation here and it's hard to tease all of that out looking at this.

Of course, it is bothersome to me that in that medium cost third almost 75 percent of institutions have a negative Medicare margin. And so I don't know what our set point is but are we driving to only 20 percent of institutions or something should have positive Medicare margins? I'm not quite sure where we might be taking our thinking here.

The other thing I'll mention is in the past we've seen other analyses, for example, that high Medicare margins are highly correlated with the receipt of DSH and IME. So there's so many moving parts to all of this that it's hard to get your brain around one story when there's some other

ones out there that we've looked at in the past, I guess is part of it.

The question about how all of this flows geographically to me is very interesting because a market basket update obviously turns into something once it goes through the sausage machine. In my institution, we have not seen a market basket update in all the years I have been in my current position. I think the best we've ever seen is about two. That's because once you put in wage index, the hospitals that are reclassified, who's getting high DSH and IME and all those things, it really does make a difference how it flows done to the individual institution.

As a separate exercise, I think it would be fascinating to look at the Bell curve of PPS hospitals and kind of see what happens. Who's actually getting a negative update versus who's getting a 5 percent or a 6 percent update. I've never seen that information and it would be very interesting to me.

If we were to go to market basket minus productivity of 1.5 and a 2 to 5 percent take away for value-based purchasing program, there would be many institutions that have more than their entire bottom line

right out of the chute at significant risk.

So I hope that we can be thoughtful about how we design all of these very intricate moving parts as we look at the system.

On the productivity, I know that this is a philosophy. It's not targeted to health care. And I couldn't agree more that health care, we should all be trying to be become productive and work on that because we can do a lot better on it. It really is a difficult task, I'll just say, when you're on the front lines. We are seeing some tremendous opportunities, for example, in transcription. PACS radiology is giving us some tremendous economies because of not having to use -- in fact film and chemical savings almost pay for the installation of those systems. Those things are very positive. As you implement clinical IT chart pulls and the cost of staff to do that start to go down. So there's a lot of promise.

On the other hand, when you look at MS-DRGs and HIPAA and all of the regulatory things that have come our way, there have been significant costs that we've had to add in terms of staff to deal with that.

Even the complexity of billing and collecting in

American health care is a very, very strong financial driver for those of us in the business because we are adjudicating all these different benefit designs and meeting with patients. So it's hard to create productivity there. It's a lot easier in the banking system or in the computer business to create productivity on the billing and collecting side.

And so I'm a little worried that I don't exactly understand what's driving all of the increased productivity outside of health care. The other thing we don't really have going on in health care is outsourcing of jobs to foreign countries, which I'm assuming is part of some of the productivity increases we're seeing in health care.

So I worry about that. I worry about this sense that technology is going to get paid for via P4P. That's certainly hasn't happened to us yet. I think that the whole issue of how we fund what we seem to believe is a really important next 10 year driver in terms of the importance of that in quality and cost savings, to me it's not that intuitive that we're going to pay for it through pay-for-performance.

Those are just some of my concerns. Back to the

margin issue, I'm not sure what framework we're using right now and what constellation, what subgroup of hospitals do we feel represents where we want to target updates? Because it's confusing to me for the reasons I mentioned.

DR. MILSTEIN: This, for me, is a pivot point that relates directly to our discussion of sustainability and how do we transform our role in relation to these individual micro-decisions into something that writ large might have a prayer of addressing the sustainability challenges that we periodically focus on? I think Nick's comment, for me, is a great starting off point because it is exceedingly hard in any industry, particularly in an industry constrained by some -- limited in its ability to offshore or outsource -- to achieve high levels of productivity gain.

That said, because this happens to be one of our industrial sectors to which systematic process reengineering is late arriving, the opportunities are terrific, enormous, at least as reflected in the National Academy of Engineering IOM report of several years ago.

In some ways precisely because it is so hard to improve productivity that I believe that one of our best chances for doing it is to make it, that is make

productivity increase a so-called "stay in business" issue.

So I completely agree with Nick's points and I also, looking at Nancy, want to acknowledge the fact that there is this problem of the balloon bulging. Putting too much pressure on Medicare does result in some inability on the private sector side to resist hospital increases.

But with all that said, I think that if we don't start setting higher expectations with respect to productivity increases and make productivity increase a "stay in business" issue, it's not going to happen precisely because it is so hard to do.

MR. HACKBARTH: Nick, let me take a stab at responding to your question about the framework that we're using. I think the way you put it was what percentage of hospitals do we think is appropriate to make a profit on Medicare. A couple of thoughts about that.

I don't think of it in exactly those terms, but I would say that I don't accept that there ought to be -- Medicare ought to pay enough to accommodate all of the cost increases experienced by hospitals or the cost increases experienced by 80 percent of hospitals. I think, given the fiscal challenges facing the program, it is appropriate to

say our policy has to be to apply pressure to change those underlying trends. Not accommodate them, change them. If we continue on the path we're on, we're all ruined financially. And so I don't think of this as accommodating, but changing.

That still begs the question how much pressure is too much? And that's implied by your point. That's a difficult question to answer, how much pressure is appropriate and how much is too much?

On the issue of well, when Medicare squeezes, the private sector has to pay more, the cost shifting argument, in the last few years I've, frankly, come to see it the other way around. The problem that we have right now, as I see it, is that the generosity of payment in the private sector is driving up costs for the reasons that you alluded to. Hospitals can say well, I'm losing on Medicare but I've got all this money coming in from the private side so I can afford to take the Medicare loss. I've got the cash.

So the policy of hospitals, the spending decisions of hospitals I fear are being driven by the generosity of payment in private sector. Then when it comes to Medicare, oh, our costs per case went up 7 percent. You need to

accommodate it or more hospitals are going to lose money.

Medicare can't be in that cycle. It just leads to a fiscal dead end. It still, as I say, begs the question how much pressure is too much in any given year? And I confess to not knowing an easy way to solve that problem.

DR. WOLTER: I wouldn't want to have anything I said characterize as promoting that we cover all increases in hospital costs. I certainly am not arguing that point by a long shot.

And secondly, I really do think it's an oversimplified argument and an unbalanced argument to say that private sector largess is the only issue. I think there's a lot of things going on in the marketplace and not all markets are the same. And so I just want to be sure we try to think through some of the subtleties and difficulties of what's going on here.

In the past, we've said that increasing the market basket overall isn't necessarily the way to tackle certain problems. I think that's true in a case like this, too. We're depressing overall payment when some of the problems may be targeted in various markets but not others. We should be thoughtful about that, as well.

MR. HACKBARTH: Just to be clear, I completely agree with your point about the issues and the dynamics being different in different markets. Part of the problem with the program is that sometimes the tools that you have are very crude ones. National updates don't reflect that diversity and variety of circumstance and that's one of the shortcomings of this system.

But I do believe, as Arnie says, we've got to think about how to change the cost trend. And that implies payment levels for many institutions, at least, that are below the rate of increase in costs. That in turn implies declining Medicare margins. There's no way around that.

And so the fact that a large number of hospitals lose money on Medicare and more are continuing to lose money each year on Medicare, I don't per se see as the reason for oh, you've got to increase the update. We can't afford that way of thinking about it.

DR. CROSSON: I realize we're on the update work now and not program changes but I just would like to bring that for a minute the observation that Ron made a little while ago because once we are done with the update process we're going to be back to -- later next year, we're going to

be back to discussions about what can we do to make the situation better?

I think the observation that the low-cost, high-quality hospitals tended to have better physician/hospital relationships is an important one. If our ideas on bundling and some of the other ideas about progression to more integrated systems are going to work out, we ought to take advantage of every opportunity we can to try to understand currently what seems to be working. Are these hospitals structurally different? Do they have different governance relationships with their physicians? Are these hospitals who are managing to figure out reasonable ways to provide incentives to physicians that are within the legal framework that they operate under? How much does this have to do with information technology use?

It seems to me that as we elaborate that area of our policy recommendations, using this subset of hospitals -- if they are, in fact, a real subset -- as an investigation ground would be a useful.

MR. HACKBARTH: Others?

Just a couple of quick questions. If you go to slide 11, as I understand it the 2006 data here is actual

data now?

MR. ASHBY: Yes.

MR. HACKBARTH: And one of the many challenges that we have in making a recommendation on this issue is that we've got old data and we have to project foreword based on our assessment of cost trends just to make a projection of what the margin is going to be -- in this case in 2008, which is our taking off point for making a 2009 recommendation. So it raises a question how good are they at making those projections? How good have they been in the past?

So just as a point of information, when we were protecting the 2006 number of couple of years ago now, what was our projection? How close did it track with reality?

MR. ASHBY: Last year we projected a minus 5.4 for 2007 and that one appears to be right on track, actually.

MR. HACKBARTH: It does?

MR. ASHBY: Yes, for where we would be in between the two years.

DR. MILLER: In 2006, you were saying that that number was affected more by policy changes than secular trend. The point you just made is that 5.4 might make sense

as a path between 2006 and 2008. But you said 2006 was a function of policy changes, which is also what always makes this art -- well, makes it an art. Because you can take secular trends into account.

But then if there's policy action or environmental regulatory action --

MR. ASHBY: But we did take those policy changes into account. The policy changes are ultimately among the easier things to project accurately. The cost growth is more difficult.

DR. MILLER: If you know they're going to happen.

MR. ASHBY: Exactly, right.

I do have to clarify this comment anyway to be that last year and the year before we didn't know that we would have MS-DRGs coming in, and that has a potential behavioral effect as we talked about extensively here. We were not taking that into account the last year because it was not yet known to be a fact. The coding adjustment offset was unknown. So it's a little bit difficult to be accurate in that period.

MR. HACKBARTH: Let's turn to 12 for a second. For the 2006 numbers here, you highlighted the reversal of

the urban/rural that last year when we were going through this exercise the rural hospitals actually had marginally better margins and that's reversed. What about the teaching categories? Any significant differences there from what we saw last year at this time? The 2.8 is lower than I recall from last year.

MR. ASHBY: Right. All three of the groups declined from last year. The major teaching went from 5 down to 2.8. The other teaching went from minus 3.6 down to minus 5.4. And the non-teaching went from minus 6.8 to minus 8.5. So not much of a pattern change.

MR. HACKBARTH: Any others?

DR. WOLTER: I'll just ask on outpatient again, because I do bring that up every year, but it's been pretty prominently negative from a long time, pretty much since the outpatient PPS was instituted. Did we have a presentation earlier this year -- we're coming back to look at APCs in a different way, so that we wouldn't want to address the update differently. We're going to tackle it some other way? Is that what we're going to do?

We were talking about looking at different bundling in the outpatient system, as I recall. Are we

going to talk about the issue of pretty significant margins in that program related to some of redoing the bundling? Or are we sort of okay with levels at negative 10 or 11 percent?

MR. HACKBARTH: I'll take a crack at it. The issue about the level of payment is best addressed during the update discussion. What we're looking at in terms of changing the method of payment, ordinarily we wouldn't combine that with a level discussion.

MR. ASHBY: Let me just add, in terms of the differences in level, we still continue to think that to a certain degree that is probably due to cost allocation issues that press down the outpatient margin.

But we also have to remember that, as we've been talking about, the IME payment and also the disproportionate share payment have sizable subsidies built into them. And those subsidies are delivered on the inpatient side. So they raise the inpatient margin and not the outpatient. Of course, the objective is to help teaching hospitals, not to alter the inpatient/outpatient relationship.

DR. DEAN: Just a quick question. The definition rural here is -- you get into all sorts of problems with

that. I guess those of us that really live in the boondocks, every hospital that is truly rural is a critical access hospital now. So this definition, I'm sure it's hard to exactly know where it fits.

MR. ASHBY: There are still 1,000 rural hospitals that remain in PPS in addition to the 1,300 or so that are CAHs.

MR. HACKBARTH: Just for the record, Jack or Jeff, would you tell us what the definition of rural is?

DR. STENSLAND: We use anybody outside of the MSA.

MR. HACKBARTH: Which is the way the term has been used in Medicare law for a long time.

DR. DEAN: Functionally, some of those are not distinguishable from "urban."

MR. HACKBARTH: Yes.

DR. KANE: Is the Medicare margin overall for the critical access hospitals then 1 percent by definition?

MR. ASHBY: For inpatient and outpatient services.

DR. KANE: It's combined.

MR. ASHBY: It would be, right. They have both acute services and other things, as well.

DR. KANE: Do we know how they're doing

financially overall?

MR. ASHBY: Overall you mean all payer?

DR. KANE: All payer.

MR. ASHBY: On an all payer basis, they are doing better than other hospitals. They have a higher margin. All rural hospitals together, as a group, have higher total margins than urban hospitals.

DR. MILLER: Just to be clear, everybody understands that the rural number in that table does not include the CAH. That's clear to everybody?

MR. HACKBARTH: Anybody else?

Okay, thank you. More on this next time.

Next in the lineup is skilled nursing facilities.

DR. CARTER: We're going to cover three areas this afternoon. First, we'll discuss our analysis of the adequacy of Medicare payments using the same framework that Jack just walked through. Then we're going to consider recommendations in two other areas, revising the publicly reported SNF quality measures and implementing a pay-for-performance program for SNFs. I've summarized the per diem payment methodology in your paper and I won't go over that here.

In fiscal year 2007, spending for SNF services was $21 billion, up over 9 percent from 2006. Between 2006 and 2007, the pace of total program spending increased due in part to the implementation in 2006 of nine new high-paying case-mix groups for patients with rehabilitation and extensive services care needs.

But the growth in program spending has slowed since 2005, in part reflecting the decline in the fee-for-service enrollment and the concurrent expansion enrollment in Medicare Advantage, whose spending on SNFs is not included in these numbers.

When we put the spending on a for-service enrollee basis, we see that spending has increased faster than overall spending rates in the past two years.

Most Medicare beneficiaries appear to experience little or no delay in accessing SNF services, especially if they need rehabilitation services. Medicare is seen as a good payer and many SNFs have increased their Medicare shares.

While access is good, some patients with complex care needs may be delayed in getting placed in a SNF as discharge planners seek a placement in a SNF that is willing

or able to take the patient. Last spring we were told by hospital discharge planners that patients requiring complex wound care, ventilator care, or expensive IV antibiotics could be hard to place.

The supply of SNFs was almost identical in 2007 as it was in 2006 with just over 15,000 SNFs. The number of providers has increased slightly since 2001. Even though the share of hospital-based units continues to decline, there were 11 new hospital-based units during 2007.

When adjusted for the number of fee-for-service enrollees, there was a 4.1 percent increase in covered days and a smaller increase in admissions between 2005 and 2006. Some of the volume growth may be the result of the 75 percent rule for IRFs and the shift in site of service for some beneficiaries.

There continues to be a shift in the mix of patients treated in SNFs. One shift is the result of the nine new RUGs groups that were added to the top of the hierarchy that I mentioned before. These highest payment RUGs categories accounted for 26 percent of all RUG days in 2006, pulling cases away from the rehab only groups. In 2005, rehabilitation RUGs accounted for 83 percent of RUG

days but only 60 percent in 2006.

The other shift that we saw is the continued concentration of patients classified into the highest therapy payment groups. The ultra high and very high -- and those are the two groups on the left -- made up 59 percent of rehab days, and that's up 7 percentage points from the previous year while the share of days grouped into the high and medium rehab categories -- those are the two groups on the right -- declined.

These changes could be a function of the shift in the site of care for treating patients with higher care needs or they could reflect the payment incentives of treating patients in the higher paying rehabilitation RUGs. The continued expansion of the number of patients classified into rehab RUGs and the amount of therapy furnished to them underscores the importance of assessing the value of therapy services.

Most of you will remember Dr. Kramer's presentation from the spring when he described the work he's done for us looking at the two trends in quality measures that we use instead of the nursing home compare measures. These two measures are risk-adjusted rates of community

discharge and potentially unavoidable rehospitalizations for five conditions.

Looking at the six-year trends, we see mixed performance regarding the quality of care. First, the risk-adjusted rates of community discharge were almost identical to the level they were five years ago, having declined and then having improved in the last two years. The risk-adjusted rates of rehospitalization have steadily increased throughout the period, indicating poor quality.

One interesting finding that we had was when we looked at differences by ownership and controlled for case-mix and facility type, we found that for-profit facilities had slightly higher community discharge rates, indicating higher quality, compared to nonprofit SNFs but they had higher potentially avoidable rehospitalizations, indicating poor quality. Unmeasured case-mix differences and other factors that were not accounted for could explain some of these differences in quality measures and we plan to analyze this result further.

The vast majority of SNFs are parts of larger nursing homes that seek capital for construction and capital improvements. Even though Medicare is a small share of most

homes' revenues, because it is a generous payer homes want to increase their Medicare shares. Analysts told us that homes treating above average shares of Medicare patients are viewed more favorably than other homes.

SNF access to capital was very good during most of this past year. Analysts told us that investment has slowed considerably since the late summer. They also said that nursing homes will continue to have access to capital but it will be more expensive and the terms will likely to be more restrictive. While access to capital is expected to be tighter, this is related to the lending and real estate trends and it is not a reflection of the adequacy of Medicare payments. Medicare continues to be a preferred payer.

Aggregate Medicare margins for freestanding SNFs in 2006 were 13.1 percent. This is the sixth year in a row that freestanding facilities have had aggregate margins exceeding 10 percent. This year's margin was a slight increase from last year's, reflecting slower cost growth and higher payments for the new RUGs categories. There continues to be variation in the financial performance across facility groups that we typically looking at. Up

here you can see they range from 3.1 percent for nonprofit SNFs to 16 percent for the for-profit SNFs. Nonprofits had higher daily costs after adjusting for case-mix and higher cost growth that for-profit facilities. Comparing freestanding SNFs in the top and bottom quartile of Medicare margins, we found that high-margin SNFs had case-mix adjusted costs that were one-third lower, they had higher average daily census, and longer lengths of stay. Unmeasured case-mix differences in their patient mix could also explain some of the cost difference.

Hospital-based facilities continue to have very negative margins, and this year in 2006 they were a minus 83.8 percent. We have often discussed the reasons for the large differences in the per day costs between hospital-based and freestanding facilities, including their higher staffing levels, unmeasured case-mix differences, the allocation of overhead from the hospital, and very different practice patterns.

In modeling 2008 payment and costs, we consider policy changes that went into effect between the year of our most current data -- which was 2006 -- and the year of the margin projection. Except for accounting for full market

basket updates for each year, there were no other policy changes to consider.

We estimate that the Medicare margins for freestanding SNFs in 2008 will be 11.4 percent. We think this is a conservative estimate because we used actual average annual cost increases since 2001 and not their market basket, which is lower. We did not factor in any behavioral offset that may increase payments.

This leads us to our draft recommendation, which was last year's recommendation, to eliminate the update. We believe this is again a reasonable recommendation, given that margins are higher in 2006 than they were in 2005 and are more than adequate to accommodate cost growth.

This recommendation would lower program spending relative to current law. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

Now we turn our attention to SNF quality. CMS currently uses five quality measures for short stay post-acute patients in its nursing home compare website and these are the measures that are listed on this slide. Experts have raised a host of problems with the delirium, pain, and

pressure ulcer measures that undermine the accuracy of these measures. We talked about some of these problems with Dr. Kramer when he was here in the spring.

First, there are timing problems associated with the three measures that use patient assessments. Because SNFs are not required to conduct patient assessments at discharge, there is a systematic bias in the patients captured in a measures since half of SNF patients don't stay long enough to have a second assessment.

For the cases that are included in the measures, the lack of specific times when assessments must be conducted means that the differences in scores may be the result of when the assessments were conducted rather than differences in patients. A further complication is that the patient assessment questions ask about care delivered in the last 14 days, which can be that the measures were reflecting care that was provided in the hospital rather than in the SNF.

In addition to these timing issues, the measures do not capture the key goals of care for most SNF patients, to improve enough to be discharged back to the community and to avoid an unnecessary hospitalization. Furthermore, for

each measure, there are definitional problems that should be addressed to make these measures more accurate. For example, reported differences in pressure sore and pain measures can reflect differences in staff's abilities to assess patients, not actual differences in patients. The pain measure is confusing and narrowly defined. The pressure sore measure was found to be not valid. And finally, the delirium measure is non-specific and is insensitive and misses a large share of patients with the condition.

Reflecting the measurement problems, CMS's planned pay-for-performance demonstration does not intend to include these three post-acute stay measures.

The alternative measures that we use are well-suited to assessing the care furnished to short stay post-acute patients. Experts told is that these measures provide better information on whether patients benefit from SNF care than the currently reported measures and they capture the key outcomes for beneficiaries that are placed in SNFs. Moreover, the measures include most SNF patients and do not reflect the care during the preceding hospital stay. Finally, the data are readily available.

Since MedPAC began using these two measures as the measures of SNF quality, we had a contractor evaluate three aspects of the measures to assess their readiness for public reporting. They examined how robust the risk adjustment method was, the sample size needed at each facility for stable measures, and the time period assessed by the measures. They found that robust risk adjustment method was feasible using administrative data, a relatively small sample size was needed for stable measures -- it was 25 cases a year -- and that the measures that considered 100 days of care were preferable to those that considered 30 days.

This brings us to our second recommendation. To improve quality measurement for SNFs, the Secretary should: add a risk-adjusted rate of potentially avoidable rehospitalizations and community discharges to its publicly reported post-acute measures. The Secretary should revise the pain, pressure ulcers, and delirium measures, and requires SNFs to conduct patient assessments at admission and discharge.

This recommendation does not affect Federal spending relative to current law. It is expected to support

quality improvement efforts. The increased provider administrative burdens associated with conducting the assessments could be minimized if the five-day assessment was replaced with one done at admission and if the discharge assessment included only a few key items. CMS would incur modest administrative expenses associated with adding the new measures to its publicly reported set and developing a pared back instrument for use at discharge.

Now I'd like to turn to pay-for-performance.

When the Commission first considered the settings that were ready for linking payment to quality, SNFs were not among them. This was, in large part, because evidence-based accepted measures with adequate risk adjustment were not available for SNFs and the publicly reported measures were problematic. In 2006, the Institute of Medicine came to the same conclusion, noting the problems with the publicly reported quality measures.

Over the past two years, the Commission has carefully evaluated the readiness of the two measures that I just discussed and we've concluded that they are ready to be included in a pay-for-performance program. They meet the design criteria that MedPAC has talked about for performance

measures. I'm not going to go into these but these are listed on the slide and should be fairly familiar to you.

There are two features of the SNF industry that would need to be taken into account in designing a pay-for-performance program. First, Medicare is a small share of the business at most SNFs and may not, on its own, be able to influence provider behavior even as a preferred payer. Compounding this low share of SNF businesses is the fact that provider margins for Medicare patients have been relatively high for the past five years, which may dampen the impact of a reward or penalty of pay-for-performance programs.

cost of making improvements to score better on the performance measures may exceed the financial reward they might obtain from the pay-for-performance program. In this case, providers could elect not to improve their quality. Given the relatively high margins and low Medicare shares, the pay-for-performance program may need to be designed with a larger set-aside than the 1 or 2 percent generally considered appropriate for provider settings. On the other hand, because Medicare is a preferred payer, facilities may pay close attention to how they can increase

their Medicare payment.

This leads us to our third draft recommendation: the Congress should establish a quality incentive payment policy for skilled nursing facilities in Medicare.

We think that the two measures that we use, the community discharge and potentially avoidable rehospitalization rates, are available and CMS already collects the data necessary to calculate the measures. The proposed measures should form the basis of a starter measurement set that could be added to over time.

This recommendation would not affect program spending. The program would be designed to be budget neutral. A pay-for-performance program should improve the quality of care for beneficiaries and it would raise or lower payments for individual providers, depending on the quality of their care.

And what that, I'll end my presentation and look forward to your discussion.

MR. HACKBARTH: Carol, when I was out, did you talk at all about the Medicaid issue and total margins being lower than --

DR. CARTER: No, I didn't.

MR. HACKBARTH: And as I recall, it wasn't in the paper either, was it?

DR. CARTER: No.

MR. HACKBARTH: For the benefit of the new commissioners, we ought to touch on this issue.

Carol showed the projected margins for SNFs for Medicare patients and 11.4 percent, I think, was the number; right?

DR. CARTER: The projected margins?

MR. HACKBARTH: Yes.

DR. CARTER: Yes, 11.4.

MR. HACKBARTH: Based on that, the draft recommendation was for no update. Each year we've talked about this in the recent past a response to that has been well, the overall SNF margin is significantly lower because Medicaid tends to be a poor payer. The argument continues that in evaluating payment adequacy for Medicare, we ought to take into account the overall margin and not just the Medicare margin, which we have been unwilling to do for several reasons. But the most important is that if, in fact, there is a Medicaid payment problem, increasing Medicare rates does not get the money to the right people.

If you increased Medicare payment rates, the institutions that will get the most money under that approach are the ones with the largest Medicare shares and the lowest Medicaid shares. So the rich would get richer and the poorest would be not helped as much.

So if you have a Medicaid driven payment problem, the solution really needs to be in Medicaid as supposed to through manipulation of the Medicare rates. That has been our position in the past.

DR. CARTER: I guess the other thing I would add is that then there is an incentive for states to lower their rates.

MR. HACKBARTH: That's right. If the message becomes well, the Federal government has assumed responsibility for the total margin and the overall financial stability and well-being of the SNF industry, it is a veritable invitation to the states to say oh, since the Federal government is going to cover it al, if we face a budgetary squeeze this is a place where we can cut and it will be made up for elsewhere, which is not the right policy incentive.

DR. KANE: There's actually another one, which is

if the person who is in the long-term care bed is on Medicaid or even self-pay, if they can get them back in hospital for three days they get to start that clock over on Medicare for however long it lasts. So that the better the Medicare payment, the more the incentive to not treat something in the nursing home if you can move them back into the hospital and start it over again.

Do we have a sense, by the way, for these homes of how many of their long-term population gets churned through the -- what the rate of -- churn is the wrong word but actually it's the right word. They kind of put people through the hospital and get them back into Medicare for a few days and up their overall return on that person. Do we have a sense of that? Because to me that would be a really important measure of quality and it does affect the Medicare population but it's sort of a Medicare/Medicaid problem.

DR. CARTER: We've looked at two different things, both of which suggest that this is a small problem but we've thought more recently that maybe we should do some more analysis because we do keep hearing about this. I think it was between 5 and 8 percent of patients that are discharged from a SNF go on to be placed in a nursing home and sort of

the cycling through of multiple stays was somewhere -- what I'm remembering is 5 to 8 percent.

But we keep hearing this as an issue and so we were wondering if we want to look more into -- it could be a concentrated problem but it's focused on duals or it's focused on some set of providers or types of patients where it seems like a bigger problem even though it's a sunset. But we haven't done much more work than what I just said.

But that said, the majority of patients in nursing homes are Medicare beneficiaries that no longer qualify for a Part A covered stay.

MR. HACKBARTH: Other questions, comments?

MS. BEHROOZI: Like Nick, you could probably just take what I said before and insert it into the transcript here. I think it was only from the meeting last time.

I absolutely don't disagree with the recommendations at all but, Carol, as we've discussed before and as you've noted in the paper, staffing levels are intrinsically related, according to Dr. Kramer's work, are intrinsically related to quality in nursing homes. And the CMS demonstration project on pay-for-performance that you described in the paper uses staffing levels at the same

level of importance as potentially avoidable rehospitalizations. Staffing levels are worth 30 points as potentially -- and so are potentially avoidable rehospitalizations.

So again, I really urge that the Commission look both for the quality measures and then ultimately in the design of a pay-for-performance program at staffing levels, particularly in connection with the discussion that we were having last time about bundling payments and moving away from a service-by-service payment system to assure that we don't encourage stinting on care and ensure that we maintain quality levels.

MS. HANSEN: A follow-up on Mitra's point about staffing, and I think there's more in the chapter about looking at stability of staffing and the type of staffing. One of the things that I know has to do with looking at payroll as a factor now. But the one thing that does come up, and it apparently is a practice sometimes an actual nursing homes -- and I don't know that we can get to it -- is to use positions to do things that are non-care even though they are care positions. So in other words, they may be not actually giving direct care to the beneficiaries but

they're doing other kinds of things.

I don't know that payroll per se gets at that. So it really speaks to the quality of time that goes on. That also makes a difference.

The other comment is still the follow-up that I believe we had talked about and I think something is being reviewed in Congress relative to the ownership aspect of the private equity community getting into this. And I know this is something that we have to divorce any ownership per se to actually the performance and the quality. So I appreciate that. But it's just when there are issues, how does one track down accountability for that?

I just didn't know whether we were doing some more of that.

And then finally on page 10, when we look at some of the different performance of the profit margins that occur, it's so palpably different to see the line for the not-for-profit at the 3.1 percent, as compared to some of the other -- in this case say a for-profit of 16 percent margins. So just whether or not we can delve into that a little bit more as to whether or not, going back to last year's discussion, it's the composition of proportionality

of nursing homes as to whether it's the not-for-profits taking on more Medicaid populations that cause that difference or what that is teased out to be.

So we do hear those mixed stories about some systems that I think that you mentioned do get caught. And yet other providers do very well with this kind of margin.

DR. CARTER: I know a few things that relate to some of what you're talking about. We know that nonprofits had higher cost growth and they have considerably higher costs per day. Those are case-mix adjusted so they have higher costs.

When I talk with market analysts, they did think that there would be much less investment by private equity firms in the nursing home industry in the future, that the low cost of capital that had fueled their interest in the sector has probably been significantly reduced since the late summer. So at least that trend, there's still some investment that is there, but I don't think we're going to see the same kind of continued investment necessarily in the sector that we had been seeing.

We have not look specifically at private equity ownership. That's not something we have available in our

data sets right now.

We could look at chain ownership and how those quality measures compare, but we haven't done that. And it would take a fair amount of work actually to get that variable in shape and cleaned and ready to use.

DR. MILLER: [Inaudible.]

DR. CARTER: As you know, I presented last time. We have quite a bit of reform work that's on the agenda looking at paying for non-therapy ancillary services in a more targeted way and moving away from paying per service on the therapy side. We haven't looked yet at -- I know Urban is working this week on looking at the impacts by different groupings of SNFs to see how different groups will be affected by this. And it's something we will report on either in January or March.

DR. MILLER: One of the problems, Jennie, is that if the nonprofits are taking a very different type of patient that requires much more non-therapy services, ancillary services for example, then some of these changes might address what you're talking about or at least move in the right direction. That's where we're midstream right at the moment.

MS. HANSEN: I think the whole question of the different diagnoses, certain diagnoses, whether they go to certain other ownership types of nursing homes that we're talking all the ventilator conditions tend to do quite well there, as compared to people with skin breakdown and issues that are there. So is the profile different amongst them?

MR. HACKBARTH: Bruce, if you'll bear with me I want to keep you on hold for just one more minute here. Before we get too far away from Mitra's comment, I just want to engage with her a little bit on that.

My recommendation, like yours, was an Andy Kramer said that there was a positive relationship between staffing and quality. And that sounds intuitively reasonable to me.

Having said that, when we talk about pay-for-performance there are different types of measures that you might use. And the idea would be that the pay-for-performance based on outcome, but outcome is often difficult to measure, requires sophisticated risk adjustment and the like. And so we look at other potential types of measures for P4P.

Sort of a second-tier is well, clinical process measures that through research have been shown to be linked

to achieving good outcomes is sort of a second level below. Clinical process is not quite as good as outcome. You could be following the process but not doing it well, I suppose, and not achieve the same high quality outcomes.

A third, still further removed from the ultimate outcome, is structure. And I guess staffing would be a sub-variety of structure and the link is, for many structure measures, still more distant.

I say that staffing seems almost like maybe even a fourth category in that it's a measure of inputs. And so you're saying well, we're going to pay more for certain inputs on the basis that they seem to be related to quality.

I want to create the right incentives for SNFs. I want to improve the incentives that we've got. But I'm worried that we're getting a little far down the causation chain and I wanted to give you a chance to react to that.

MS. BEHROOZI: As I recall it, and I should have done a little more homework and looked at Dr. Kramer's paper from last year. But as I recall it, it's not an open-ended thing. It's not the more bodies you throw at it -- as Mark said last year, I think -- that the better the outcomes are. There is a point up to which you get the highest correlation

with the two measures. I think it was with particular respect to the two measures that we're recommending that are the ones to be used. And then beyond that you don't get any additional benefit from having any higher level of staffing.

It's about a very specific structural measure as opposed to generally staffing. It's about the right kind of staffing, and goes to somewhat what Jenny was saying about the type of care that you offer. It's not just how people are there but what type of people and what they're doing with their time. But you can't always measure exactly those things, exactly what they're doing. So sometimes you have to use proxies. So I think that's one of the reasons you move down that ladder, you can't always quite get at the outcomes. So you also have the process and structural measures, particularly when you see that there's a high correlation.

In terms of what you said about paying for inputs, we want the inputs, we want to make sure that they have value, that we're paying for the right things.

MR. HACKBARTH: [Inaudible.]

MS. BEHROOZI: But we want to make sure that what we're paying for produces the result. So if there is strong

evidence, strong evidence as I recall from the paper last year, that there is a correlation, that you get value from that input that's where I think we should be spending our money.

And then again, as Carol cited in her paper, the CMS demonstration is very specific about the type of staffing. It's RN hours per resident per day, total hours per resident per day, and turnover rates also, which goes to the way in which care is provided, not just having a body next to the bed. It's got to be consistent care.

So I think there are parameters around it that modify a little bit of the characterization.

MR. HACKBARTH: We've got a couple of people interested in this. But first, I'd like to ask Carol, you have a draft recommendation here that we recommend P4P for skilled nursing facilities but does not include this. You saw the same research that we saw in the spring. Why didn't you include it as a measure?

DR. CARTER: I knew that we prefer outcome measures and so I was sensitive to some of the work certainly that we've supported. I knew the work that we have sponsored shows the relationship between these two

measures and quality.

Andy's work -- and there's actually a very large literature that relates staffing to quality measures -- it's mostly positive. It's not uniformly positive.

And I'm trying to think, I'm not sure, most of that literature does not look at these two measures of quality. They use lots of other measures. And mostly it supports the relationship between staffing and quality measures but the quality measures were not these two.

Are you asking me my personal preference? I knew that we had a strong predilection to look at outcome measures.

DR. MILLER: The last time this exchange occurred, one of the comments you made was if I have the outcome, why would I go to the thing that's correlated with it?

DR. REISCHAUER: Why count it twice?

DR. MILLER: That was kind of your --

DR. REISCHAUER: We should look for other outcomes that also might have this relationship rather than count the input --

DR. CARTER: Or something like improvement in ADL functioning would be a great measure.

MR. HACKBARTH: Just so I'm clear, you're saying that Andy Kramer actually found that the inputs correlate with the two measures that you've proposed very strongly?

DR. CARTER: Yes.

MS. THOMAS: One of the things I recall, too, on the readmission measures, there are five conditions that are particularly amenable to prevention by good nursing care. So it's actually not that surprising that they're correlated because you pick those conditions because they are associated with good nursing care. So we are, in some ways, capturing that dimension through that measure already.

MR. HACKBARTH: I have a couple of other commissioners, Dave and Jack, who wanted to leap in on this point and then I've got to get back in my queue.

MR. DURENBERGER: Just quickly, as I listened to the two trains of discussion, the one on ownership and time and staffing and things like that, and now Carol's response is the Medicare eligible. What I'm really interested in is Medicare maximizing its buy? Am I assured of better post-acute care, not just SNF care?

In other words, I understand it might be SNF, it might be home health, it might be some other alternative.

But it seems a larger goal -- and that's why we talk about outcomes -- a larger goal is being able to compare for a particular discharge from the hospital, to be able to compare which is doing the best job and where am I most likely to get the best care? It seems to me that's the context we should keep the specifics of SNF quality.

DR. CARTER: You know that there is the PAC demonstration that CMS is about to launch in two markets that is going to explicitly look at following patients from hospitalization to multiple post-acute settings with a common patient assessment instrument. So for the first time we can actually compare whether a hip fracture patient had better outcomes once it was treated in an IRF or home health or SNF. And that's really the first time that we'll be able to look at that.

MR. EBELER: I think the conversation is interesting. It's a case again whether we're discussing a recommendation or the package of recommendations. When you include recommendation three, payment for quality based on these new measures, the fact that the field knows that achieving those measures is, in part, dependent on achieving certain other things like appropriate staffing is the way to

pull that behind it. It strikes me that it's a way to do that, pull it behind it rather than identify those particular things as an outcome based measure.

DR. STUART: An observation and then a question. This relates to your slide eight on the quality measures. The observation is this, and that is that we talk about SNF. But SNF stays are just a part of long-term care stays and CMS does not a good mechanism for tracking people in long-term care other than during the SNF days.

It turns out that a fairly large proportion of all SNF admissions are buy Medicare beneficiaries who are in other long-term care stays.

That leads to the question and with respect to community discharge, and also with potentially avoidable rehospitalizations, my assumption is that these are within the SNF admission? In other words, if you had somebody in a long-term care facility and they were hospitalized and then were returned to the facility with SNF eligibility, would this thing restart? In other words, you could have somebody who was on the SNF, he goes to the hospital, back to the SNF. When does the 100 days begin here?

DR. CARTER: It begins at the SNF admission.

DR. STUART: At the SNF admission?

DR. CARTER: Right.

DR. STUART: So you could have individuals who are actually recycling here and they get rebooted back to zero?

DR. CARTER: Yes, although we talked about that before. I don't think that's a big share of these patients.

DR. KANE: Actually, I think we're not capturing what I think Bruce and I are trying to get it. So somebody gets discharged to the SNF and they use up their Part A benefit. But we know 80 percent of the people in that SNF are you not using their Part A benefit anymore. And what is their experience? They are still probably Medicare recipients but they're no longer using Part A.

So if they get readmitted -- does that count towards a readmission or not? Because if they're still in the Part A benefit and they're readmitted, we're catching that. But are we catching the part about the post-Part A SNF stay and what that readmission rate is? That's what I was asking about.

DR. CARTER: I think those are included in here because it includes 100 days from the beginning of the SNF admission.

DR. REISCHAUER: [Inaudible.]

DR. KANE: But who in the SNF -- if 12 percent of SNF patients are Medicaid Part A, who are the other 88 percent?

DR. REISCHAUER: Medicaid and private pay.

DR. KANE: And how old are the Medicaid people and the private pay people? Are they still Medicare people who are no longer using their Part A benefit?

DR. STUART: That's it.

DR. KANE: And my question is what is their readmission rate? And is that captured? Or is it only the people who are still in their Part A benefit period for which we're capturing? I don't know if that's what you were getting at.

DR. STUART: That's part of what I'm saying. I didn't get to that part. I think if you have a nursing home -- and I'll use that term rather than a SNF because I think SNF is confusing here because we use that to talk about both the facility and we talk about the eligibility period for Part A coverage.

And it is, in fact, true that if you have poor quality in a nursing home then a Medicare beneficiary who is

not covered under Part A stay stands a higher chance of being hospitalized for one of these conditions. And so there's another part of this that leads up to the stay rather than in the stay itself.

DR. KANE: I would think that would be a fairly important quality measures that families anyway would care about, regardless of whether Medicare is paying for them. The family would like to know if my mother goes in this and outstays her Part A benefit, are they going to start churning her to get her back into the Part A benefit? I don't know if we're capturing those readmissions.

DR. CARTER: We are capturing those if it happens within 100 days.

DR. KANE: But if it doesn't, we are not?

DR. CARTER: Right.

DR. KANE: Well no, but they can go out of Part A less than 100 days if it's considered that their conditions is no longer --

DR. CARTER: For sure, but it's still in the measure.

DR. MILLER: That's the sentence that is different. It's capturing what happens at 100 days, whether

or not they go out of --

DR. CARTER: It's not related to their Part A coverage.

DR. DEAN: I guess I was confused. If they're readmitted, they don't get another 100 days do they? Isn't it all within the spell of illness?

DR. CARTER: They will if it's a new spell of illness; right.

DR. DEAN: And to break the spell of illness, you've got to be out of an institution for 60 days or something like that.

DR. CARTER: You can still be in the institution but Medicare wouldn't be paying for it. You can still be in an institution but you wouldn't be in a Medicare covered stay.

DR. DEAN: The point is that a readmission after they use up their Part A benefits does not get them more Part A benefits until they break that spell of illness.

DR. CARTER: That's right.

DR. DEAN: So the churning isn't going to work unless they're completely out of the facility for the 60 -- I mean completely out of that spell of care for 60 days.

Then you get a new set of benefits. So it's a little more complicated than that.

DR. SCANLON: I guess since we're talking about what we've said in the past, I'm going to go back to some things that I've said. The more recent times it was about home health and when we were talking about pay-for-performance for home health. The issue is the heterogeneity of patients that are being served by both SNFs and home health and the fact that there is a segment of them that don't get better, that they are there in the last stages of life, they're deteriorating. We don't have standards for what good care for a deteriorating patient is.

And therefore when we think about pay-for-performance and we don't have any standards and we don't have any measures of that, we do two things. One is that we potentially create some incentive to not accept those patients. Or if they're accepted, the question is do they get the kind of care that they need when you can get rewarded for serving others in a different way? That's one huge concern I have about pay-for-performance in this context.

The second one is, and Carol raised it, is this

strange situation where Medicare is this minor payer -- 12 percent on average, but in many cases a whole lot smaller. And so the question is how does that work out in practice?

We've got sort of a demo that hasn't gotten off the ground yet but my sense is this is not something that -- that the idea of pay-for-performance for SNFs is not something that's ready to be kicked to the Congress. It's something that we need to resolve some of these questions about first before we ask the Congress to intervene.

The CMS demo hopefully will get going and it will teach us something about pay-for-performance and that we will, in the course of that as well as other research, start to expand the measures. If people are really interested in pay-for-performance, they've got to be committed to expanding the measures to deal with more of the variation in the conditions and situations that patients have so that you get more comprehensive measures. Because we don't want to create situations where teaching to the test becomes too easy and it's to the detriment of others.

Let me also say I'm a big supporter of the idea that we should be getting something when we're paying for it and that staffing is one potentially good proxy for that.

But in this context, I worry about if a facility is providing 5 percent Medicare days, how do we count the staffing for those 5 percent Medicare days? Or how do we reward that facility? Is it the overall staffing in the facility? Or is it the people that are supposedly working on behalf of Medicare patients? And how do you, in some ways, do a cost or a staffing allocation to identify what happens? And if you to it on paper there's a question of how does that relate to what happens in reality?

So I think we've got a lot of challenges here to take on. We shouldn't move away or shouldn't walk away from pay-for-performance in SNFs, but we shouldn't just kick it to a higher level and say okay guys, it's time to say go ahead and do it and let somebody else figure it out. I think we need to keep working on it.

MR. HACKBARTH: Any others?

Okay, thank you, Carol.

Next up is long-term care hospitals.

MS. KELLEY: Good afternoon. This session will address the payment adequacy for long-term care hospitals. It's actually known as LTCHs. Craig and I will follow the Commission's framework that you're familiar with at this

point.

To give a brief overview before we start, we found it somewhat difficult to get a handle on the current payment adequacy in this sector. Recent slowing in the growth of LTCH facilities, cases, and Medicare spending may be cause for concern.

Alternately, it's also possibility that we're looking at a situation where the industry is approaching equilibrium after a period of explosive growth spurred by overpayment. So that's kind of where we are.

I'll start with a little bit of background just to refresh your memory. Patients with clinically complex problems who need hospital level care for relatively extended periods are sometimes treated in LTCHs. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients. Due to these long stays and the level of care provided, care in LTCHs is expensive. Medicare is the predominant payer for this care.

Since October 2002, Medicare has paid LTCHs under a per discharge PPS and rates are based primarily on the

patient's diagnosis and the facility's wage index.

Following implementation of the PPS, Medicare payments for LTCH services grew rapidly, climbing an average of 29 percent per year between 2003 and 2005. Between 2005 and 2006, however, growth in spending slowed dramatically with spending in 2006 virtually the same as in 2005, $4.5 billion. CMS estimates that total Medicare spending for LTCHs will be $4.65 billion in 2008 and will reach $5.5 billion in 2012.

As you can see here, LTCHs are distributed very unevenly. Some areas have many and others have none. The five states with the greatest number of LTCH beds -- Massachusetts, Texas, Louisiana, California, and Ohio -- together account for 46 percent of available beds but only 24 percent of the Medicare beneficiary population.

The triangles on this map show facilities that entered the Medicare program prior to October 2003. The circles represent LTCHs that entered the program after that date. As you can see, a fair number of circles overlay triangles, indicating that newer LTCHs frequently have located in markets where LTCHs already existed instead of opening in new markets. This is somewhat surprising because

these facilities are supposed to be serving unusually sick patients and one would expect that these patients would be rare. The clustering of LTCHs and the location of new facilities has raised questions about the role that the facilities play.

CMS has been concerned that some patients admitted to LTCHs would be more appropriately and more cheaply treated in acute care hospitals. That concern has led to a number of policy changes in recent years. One of these changes has been to the short stay outlier policy. As you know, LTCHs are paid adjusted rates for patients who have short stays. About 35 percent of cases are affected by this policy.

Beginning in July 2007, CMS reduced payments further for cases with the very shortest days, defined as those with a length of stay equal to the average length of stay for the same DRG in the acute care hospital plus one standard deviation. CMS argues that the LTC-DRG payment for these cases may be too high for cases that resemble acute care cases. Many of these cases are now paid at PPS rates.

Another major policy change concerns the 25 percent rule. CMS established this rule in fiscal year 2005

to help ensure that LTCH hospitals within hospitals and satellites do not function as de facto units of acute care hospitals. The 25 percent rule generally limits the proportion of patients who can be admitted from the host hospital during a cost reporting period to no more than 25 percent. Hospitals within hospitals and satellites are paid LTCH PPS rates for patients admitted from the host acute care hospital when those patients are below the 25 percent threshold for the year. After the threshold is reached, patients admitted from the host acute care hospital are paid at the LTCH PPS rate or an amount equivalent to the acute hospital PPS rate, whichever is less.

Beginning in July 2007, CMS extended his rule to apply to all freestanding LTCHs, as well, limiting the proportion of payments who could be admitted to any LTCH from any one acute care hospital. The extended policy will be phased in over three years. The new policy creates incentives for LTCHs to admit more patients who are high cost outliers in the acute care hospital, since these patients do not count towards the threshold and to reduce the number of patients they accept from any one acute care hospital. Without such changes, the policy will reduce

Medicare payments to LTCHs.

So turning now to access, after a long period of rapid growth, the increase in the number of LTCHs participating in the Medicare program has leveled off. As the blue line shows, from 1992 to 2005 the number of LTCHs quadrupled from 97 to 388, climbing an average of 11.3 percent per year. Between 2005 and 2006, however, there was a net increase of just four LTCHs and preliminary data suggest a fairly stable situation for 2007, as well.

The yellow and green lines show that for several years hospitals within hospitals were growing at a faster rate than freestanding LTCHs, about 16 percent annually from 2002 to 2005, compared with an average of about 5 percent for freestandings. Between 2005 and 2006, the total number of hospitals within hospitals fell and this turnaround is likely due to the 25 percent rule, which we expected would have such an effect.

Nationwide, there were approximately 26,000 Medicare certified LTCHs beds in 2006 or slightly less than one bed per 1,000 fee-for-service beneficiaries. But as I mentioned previously, they are distributed very unevenly.

The number of LTCH cases grew an average of 10

percent per year between 2003, when the PPS was implemented, and 2005. Between 2005 and 2006, the number of cases fell by 2.9 percent. Most of this decrease can be explained by a 2.5 percent decline in the number of fee-for-service beneficiaries resulting from growth in Medicare Advantage. This suggests to us that access to care was maintained during the period. We have no direct indicators of beneficiaries access to LTCH services, of course, but assessment of access is difficult regardless because there are no criteria for LTCH patients and because it's not clear whether the patients treated in LTCHs require that level of care.

Turning to quality, we look at several measures that can be calculated from routinely collected administrative data. The evidence based on these measures is mostly positive, although some indicators raise concern. The measures on this slide give us a somewhat gross indication of quality. Controlling for changes in case-mix, we look at the share of patients who died in the LTCH, the share who died within 30 days of discharge, and the share who were readmitted to the acute care hospital. We want to see these rates declining over time, and that's what we

found between 2005 and 2006.

We also look at four hospital level patient safety indicators developed by AHRQ. The PSIs are intended to identify potentially preventable adverse events resulting from acute hospital care but these four appear to be appropriate for LTCHs and we've looked at them for the best couple of years: decubitus ulcers, infection due to medical care, postoperative pulmonary embolism or deep vein thrombosis, and postoperative sepsis.

Our analysis excludes patients who had any diagnoses before transfer to the LTCH that would trigger the PSIs, so observed changes in rates are not due to changes in the number of patients admitted with these conditions. The PSIs are also risk adjusted so changes should not reflect a change in patient population. Again, we want to see these rates declining and that's what we found for two of the PSIs there on the bottom, the postoperative pulmonary embolisms and deep vein thromboses and postoperative sepsis. However, there were more cases of decubitus ulcers and infection due to medical care.

Roughly two-thirds of LTCHs are proprietary and two-thirds of these are owned by one of two chains, Kindred

Healthcare and Select Medical. Until recently, the industry's access to capital has been very good. We saw fairly dramatic growth in the number of the facilities and private equity firms were investing pretty heavily in the industry. In fact, private equity firms now control a large portion of the for-profit segment of the market, controlling several small chains as well as Select Medical.

Looking to the future, though, the indications regarding LTCHs' access to capital are somewhat mixed. On the positive side, some financial analysts believe that predictions about the dire effects of Medicare payment reductions have not come to pass. As recently as October, a private equity firm acquired Cornerstone Health Group, an owner of nine LTCHs, suggesting that investors still find the industry attractive.

Some analysts noted that this industry seems very nimble, able to respond to changes in policy. As Craig will discuss in a moment, we've seen the LTCH industry be very responsive to changes to payments, adjusting their costs per case when payments change.

The publicly traded Kindred, after struggling a bit earlier in the year, announced early last month that its

third-quarter results exceeded expectations. Some of the nimbleness may stem from the fact that LTCH companies are increasingly diversified. Kindred, for example, owns more than 200 nursing facilities and a contract rehabilitation business providing rehab services primarily in long-term care settings. Similarly, Select Medical is a leading U.S. operator of outpatient rehab facilities.

On the other hand, some financial analysts I talked with argue that even private equity firms might not have access to capital at this time and they predict that we'll see much less private investment in this industry. Some of the smaller chains are already highly leveraged. An analyst suggested that uncertainty about recent and future changes to Medicare's payment policies my heighten lenders' anxieties in the future but it should be noted that, if it passes, the CHAMP Act would significantly raise the financial prospects of this industry.

So Craig is now going to walk you through our analysis of payments and costs and our estimate of margins.

MR. LISK: So how have payments for case compared to costs per case for LTCHs? Under TEFRA, a cost-based payment system, payments and costs tracked each other fairly

closely as per case payments and cost growth was relatively low and actually declined in 1999 and 2000.

Payments, though have increased significantly under prospective payment system. As payments went up, so have costs. In 2003, 2004, and 2005 payments grew much faster than costs. Much of the growth in payments was due to increases in reported case-mix of the patients going to LTCHs. CMS expected that coding under the new classification system would improve. They have made adjustments accordingly in their payment adjustments in the updates that they have given LTCHs over the past several years.

Improvements in documentation and coding can be expected to decline over time as LTCHs become more familiar with the classification system. This may have helped dampen the most recent growth in payments per case, where you see the lines coming a little closer together in 2006.

Consistent with this pattern of payment and cost growth, margins for LTCHs rose rapidly after the implementation of the prospective payment system, rising from a bit below zero under TEFRA to a peak of 12 percent in 2005. In 2006, the margins remained very high at 9.4

percent.

This next slide shows 2006 Medicare margins for different LTCH groups. As you can see, there's wide spread in the margins with a quarter of hospitals having margins 3.5 percent or less and another quarter having margins that are 19 percent or more in 2006.

The margins for hospitals within hospitals tend to be slightly higher than for the freestanding institutions but both are high. For-profit LTCHs, which account for almost three-quarters of all LTCHs, they have the highest margins followed by the nonprofits and then the government owned. The government owned are few in number, also have lower Medicare patient shares, and are also under different costs constraints than the other hospital groups.

For purposes of projecting the 2008 margins with 2009 payment policies, we modeled a number of policy changes that have taken place since 2006. These include the effects of updates and DRG weight changes, as well as some more substantive policy changes, including changes CMS made to the short-stay outlier policy in 2007, implementation of a very short stay outlier policy in 2008, the final phase-in of the 25 percent rule for hospitals within hospitals for

2007 and 2008, and an expansion of the 25 percent rule to other LTCHs beginning in 2008, and its continued effect in 2009. We've also seen some increases in payments due to coding improvements from implementation of the MS-DRGs starting with this current fiscal year.

We therefore project in 2007 and 2008, after accounting for all policies, there was a net decrease in payments each year. Thus, we are projecting a substantial decline in margins assuming providers' costs go up at market basket levels. And if they don't change their behavior in response to these policies that CMS has implemented.

We therefore project a margin of between minus 4.8 percent and minus 2.4 percent for LTCHs in 2008. The difference in this projection reflects different assumptions about the impact of the 25 percent rule that CMS has implemented. The lower margins assumed that LTCHs made no changes in the patients they treat in response to the 25 percent rule. So they accept that they'll get an IPPS payment rate for those patients and they don't change their mix of patients. The higher number assumes hospitals adjust their admissions so they stay under the limits and, thus, their payments will not be affected.

Our margin estimates essentially assume no behavioral response to the policy changes that have been implemented from 2007 through 2009. If the industry responds to these payment changes by restraining their costs, the margins you see here would likely be higher than what you see.

To sum up, we see growth and use has stabilized in this industry in 2006 after a period of rapid growth. We have seen some improvement in most of the quality indicators but some decline in a couple of the measures. Future access to capital, though, after having been very good, appears to be a little bit more uncertain.

We also know that recent policy changes will likely result in a decline in payments in LTCHs in both 2007 and 2008. However, we have found LTCHs to be very responsive to payment changes and they have a large amount of discretion over the patients they can admit to their facilities.

And as I mentioned, we have estimated margins that range from minus 4.8 percent assuming no behavioral change with respect to the 25 percent rule to minus 2.4 percent assuming LTCHs change the mix of patients so payments would

not be reduced from that policy. While we project negative margins for LTCHs, we believe that the actual margin will likely be higher as LTCHs respond to the recent publicly changes if they lower their cost growth.

So moving on to the draft recommendation. Last year the Commission made the following update recommendation for long-term care hospitals, and we are using the same recommendation as our starting point for our discussion today. The recommendation reads the Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2009.

The spending implications for this recommendation are that the Secretary has discretion to update payment rates. Thus, a zero update will produce savings relative to a market basket update if that's what the Secretary were to give.

For beneficiaries and provider implications, over time reduced margins may result in fewer LTCHs participating in Medicare. Given the availability of other types of providers, it is unclear whether this possesses a problem for access to beneficiaries.

We would now be happy to answer any questions you

may have and look forward to hearing your discussion.

MR. HACKBARTH: Thank you, Dana and Craig.

I mentioned at the outset that all of the draft recommendations were a carryover from last year. I think this is the area where there's the most significant change between the financial performance that we were projecting last year and the projection this year. So I just wanted to highlight that.

Dana, in your presentation you made a quick reference to the CHAMP Act and the fact or assessment that if it were enacted that would have a dramatically positive effect on the financial performance of the LTCH industry. Would you just elaborate on that and what was in the CHAMP Act?

MS. KELLEY: Sure. The CHAMP Act, in part would -- I'm sorry, it would call for CMS to develop patient and facility level criteria such as we have proposed in the past. It would also prevent CMS from applying the 25 percent rule to freestanding facilities. For hospitals within hospitals and satellites, it would roll back the 25 percent rule to the 50 percent level that it was at during the phase-in. It would prevent CMS from reducing payments

for the shortest stays, for the short stay outlier policy.

I think those are the major provisions.

MR. HACKBARTH: All right, questions and comments?

MS. DePARLE: You brought up last year, that was a question I wanted to ask, too. What were the margins that you were showing last year?

MR. LISK: We project, I think it was 2 percent to zero, with regard to the 25 percent rule. At that point there was only going to be impacting the hospital within hospitals.

MS. DePARLE: Glenn's comment made me think I had misremembered it because I thought he sounded as though it was a better picture last year, dramatically better. It was somewhat better. But to me it wasn't a great picture.

I think Nick is the one who brought up the ghost of Christmas past earlier, and other have -- MedPAC past -- have incorporated their comments from prior years. Last year I was troubled by where we came out on this one because I thought on similar factual evidence we did something different here than we had done in other sectors. I'm just trying to remember what the numbers were and why I thought that. In particular, I think it was the comparison between

this and inpatient rehab, I didn't think was consistent.

MR. HACKBARTH: That's true. And one of the factors was that in looking at this we looked at the previous history of substantial positive margins for several years before. So that was a factor in last year's recommendation, as well.

MS. DePARLE: Right, although this year I think things -- as Dan has said at the beginning -- look quite different. And I know these recommendations are just placeholders. But even more than last year, I would not support, at this point, this recommendation that is the draft here. I don't think that, based on the data you've given us today, that I could support that at this point, especially with what you're showing us about growth having come to a standstill.

One thing you didn't cover and I wondered if you had kind of come across this, is I've been hearing that some of the nursing homes, some of the for-profit nursing homes, have been trying to get into this business as well, and that that may be part of where some of the growth is now occurring, because it's not occurring in LTCHs. Have you run into that?

MS. KELLEY: That's something that we have heard about just recently. Let me make sure I understand your question. If an LTCH would -- if it's operating as an LTCH and receiving LTCH payments, then it would show up as a facility in our counts.

Are there SNFs that are converting wings into --

MS. DePARLE: That's what I've heard.

MS. KELLEY: They would turn up in our facility counts but that would be a different kind of an LTCH than we've seen in the past. We have heard about this but have not --

MS. DePARLE: But it hasn't shown up in your numbers then because it should show up as an additional -- you said there's only a net five additional facilities or something like that?

MS. KELLEY: What I mean is that it would show up in the POS files as an LTCH facility. Whether or not it's in the 2006 numbers --

MS. DePARLE: So maybe it's an even more recent phenomenon.

MS. KELLEY: It could be that, yes.

DR. MILLER: Also there's potentially in that

exchange two different phenomenon: the notion that somebody is saying I'm going to become an LTCH, a nursing home, kind of moving into this. Versus what you are saying, a nursing home or a skilled nursing facility saying I'm going to start taking these patients.

It's if the former, then it will start to show up in the counts.

MS. DePARLE: In the provider counts. If it's the latter, they will be getting these LTCH payments but won't show up anywhere?

DR. MILLER: No, they will not.

MS. DePARLE: They'll just get the patient at their SNF rate or whatever that is.

MS. KELLEY: And presumably in areas of the country where there are no LTCHs, the other providers, including possibly SNFs, are furnishing this care.

MS. DePARLE: Yes, that's the analysis we went through before when we were trying to determine where this was coming from.

Well anyway, it's just interesting to watch.

And finally, again you can insert my comments from several years running on this one, but what is the status of

any effort at HHS to develop criteria about the appropriate kind of patients for LTCHs?

MS. KELLEY: As you know, the Commission recommended the development of patient and facility criteria in 2004. After we made that recommendation, CMS contracted with RTI to help with that process. RTI put out a report in January of this year echoing recommendations that we had made.

Since that time, CMS and RTI have held two technical expert panels. And I think what the general consensus has been so far is that the development of patient criteria may be more difficult than had been anticipated. But I have not had an official -- we have not had an official report on that and I don't know when one is forthcoming.

MS. DePARLE: Thanks.

MR. HACKBARTH: Just to complete the discussion about changed circumstances, one of the other changes from last year, as I understand it, the two industry groups did come together to advocate for a set of patient and facility criteria, which is one of the things that we had been urging. We had been saying keep the pressure on and have

the industry come forward to help do the right thing. And that has happened.

MS. KELLEY: That has happened and those preliminary patient and facility criteria are part of the CHAMP Act. Those criteria would be implemented at first with a requirement that CMS go on to investigate their usefulness and whether there would be other additional criteria that should be applied.

MR. HACKBARTH: So is it accurate to say that there was a link in the CHAMP Act, that they said let's do the criteria, the industry supported the criteria, and then ease off on the 25 percent and some of those restrictions? Is that what they were thinking?

MS. KELLEY: I think that would be a fair characterization.

MR. EBELER: I don't have the luxury to referring back to prior remarks on this one, nor of understanding it that well.

It sounds like it's not clear exactly the clinical conditions that take one to an LTCH versus an outlier hospital patient versus an SNF versus an inpatient rehab facility. I was worried I was the only one for whom that

wasn't clear.

You put up an interesting chart on page four, the geographic map. Given that fact, is it possible to do some type of a geographic analysis of how these patients' needs are being met in different facilities in these areas? I look at that map and we're not exactly targeting the efficient Elliott Fisher locations there.

It just strikes me that if that is the situation, getting some study of what is happening in different types of places for these patients might let us long-term come to a better understanding of how to arrive at payment policy.

MS. KELLEY: MedPAC looked at that using pre-PPS data back in 2004. RTI did a more recent analysis, a similar one, looking at -- if memory serves -- looking at hospital cases that where of high severity and in that sense sort of resembled the LTCH cases. They, to my knowledge, did not isolate areas that have LTCHs from areas that do not in the analysis. But what they did find was that IRFs are frequent a substitute for LTCH care. Less so SNFs, to my recollection.

MR. LISK: And outlier cases.

MR. EBELER: Do we have a sense of differential

volume given what we know about the cases among these different areas of the country? Is this a typical Dartmouth analysis? Or does this part of the field operate differently?

MS. KELLEY: We have not looked at that. This is something I think we could do. But we have not looked at it to date.

DR. MILLER: I just want to make sure I understand. The question you're asking is does the presence of these increase the volume you otherwise see? Is that your question?

MR. EBELER: If you add up the volume in a community in an LTCH and an IRF -- is that what we're calling them? And comparable patients in nursing homes and comparable long-term hospital stay patients, what do we know?

MS. KELLEY: One thing we did look at when we did our analysis back in 2004 was episodes of illness and how patients who used LTCH services, how the episode of illness for a patient who used LTCH care differed from patients who did not.

We did find that for the entire episode, patients

using LTCH care were extraordinarily expensive. But that for the sickest patients, the difference between the costs per episode narrowed considerably which is what led us to the idea that we needed specific patient and facility criteria to define the patients that were in the facilities.

DR. WOLTER: Just a few observations. I was part of the group that did the LTCH site visits, I guess it's three or four years ago now, for MedPAC when we were starting our study in this area. What struck me on those visits was, first of all, the range of the arrangements going on and the range of quality going on. I did practice pulmonary critical care on the acute side for a long time. And at their best, I was so impressed with the kind of care that was being delivered to these chronically critically ill people. Maybe the most outstanding facility being one in Houston that's right in the middle of Houston Medical Center. For those of you who have been there, you know it's surrounded by 10 hospitals and it's an incredible source of patients like this.

An industry person told me, and I might be misremembering this so don't hold me to it, that you need about 180,000 Medicare beneficiaries to really support some

sort of an average sized LTCH facility, in terms of if you are really targeting these seriously chronically critically ill people, which would mean that we should be appropriately concerned about the -- I think it was the dots on top of the triangles on that map.

On the other hand, I think that there is a place of for these. And what we heard in the site visits also was that freestanding SNFs don't take these people. They really don't have the capability, for the most part. And hospital-based SNFs, 35 percent of them have closed in the last four or five years. So other than the inpatient rehab facilities, when there's not an LTCH present these people are being taken care of as outliers in acute care facilities or in hospital-based SNFs where margins are negative 85 percent -- which I was quite polite about not talking about that in the last section.

And so I think that the goals here of trying to define which are the right types of patients who should go into the right setting do remain the preeminent goals for the future because there is a group of patients who can be well served in this way. And since we have these various payment silos that are treating these patients in very

different ways, it's probably not the right incentives.

And then my last comment is on the 25 percent rule for freestanding LTCHs, I can imagine that not working very well in some markets, particularly rural and semi-rural markets where patients like this might tend to be referred into the only acute hospital or the only two acute hospitals in a certain market. And then from there they go to an LTCH. So it might be hard to really get down to that 25 percent situation. So you might want to keep an eye on that, also.

MS. KELLEY: Nick, I'm sorry. I should have clarified during that part of the presentation. In rural areas, LTCHs are held to 50 percent, as are areas where there is a single referring hospital.

DR. WOLTER: Just back to definitions because if an MSA is not rural, but really all the source of those patients are very small hospitals it wouldn't be direct sources. We could still run into the problem, I think.

DR. CROSSON: I wonder if we could go back to the recommendation for a second?

Looking at the last part of the recommendation, it's a little bit different than typically what we say

because it essentially says over time the reduce margins may result in fewer LTCHs participating in Medicare. Given the availability of other types of providers, it's unclear whether this poses a problem.

We generally wouldn't say something like that if we were talking about hospital updates or physician updates. We usually worry about the opposite.

So it strikes me that inherent in that is at least a question, if not a judgment, about the validity of these entities. Otherwise, we wouldn't be saying something like that.

I heard that in what Jack said and I heard something to the opposite in what Nick said. So it seems to me, and I'm not sure again we can solve it in the update process necessarily, but that's probably an important question to answer.

One of the things that I wondered as I was listening to the presentation was whether we could look at what Medicare Advantage plans are using these facilities for? Or just strictly coordinated care plans, where people are making judgments among various sorts of care and learn something that might inform future recommendations.

MR. HACKBARTH: That would be interesting to know, what coordinated care plans are doing in use of these facilities. I agree with what you say, that the update is a very, very crude tool for trying to decide how many LTCHs we want or need, which is why I believed and continue to believe that patient and facility criteria is such an important part of this puzzle.

The suspicion that we could have fewer of them and it may not harm patient care is obviously due to the fact that in large swaths of the country they don't exist and the patients are cared for. I'm certainly not qualified to address the issue that Nick raises, maybe the care does suffer because there are not LTCHs and they end up in some combination of inpatient, outlier and less effective SNF care when an LTCH is available. I certainly can't rule that out but I'm not sure it's true either.

MS. BEHROOZI: This is a very uninformed question but I wonder if there's any information that you could glean in CON states that permit LTCH? New York is a CON state that doesn't permit LTCHs, so there wouldn't be any information there. But they go through that process of looking at whether another one is needed. So I don't know

what information may be available there.

MR. HACKBARTH: And generally speaking, the relationship we found is that in the CON states there were many fewer LTCHs, if any at all, apparently reflecting a judgment that these patients can be cared for in other types of facilities.

Other comments?

Okay, thank you very much.

Jim, before we start, can we go back to LTCHs for just a second?

We do have the planned Post-Acute Care demonstration which, as I recall, encompasses LTCHs and IRFs and SNFs, and home health, the overall objective of which is to develop -- use common measures of patient need, assess the patients in a consistent way, measure outcomes in a different way, and then look at these questions of substitutability. Which institution or combination of institutions is most able to produce a high quality outcome at a low cost?

I wanted to confirm that LTCHs are part of that overall design; is that right?

MS. KELLEY: Yes, that's right.

MR. HACKBARTH: So ultimately, Bob was raising ways that we can try to get at that substitution and which is the better alternative. Hopefully, this will help us answer that.

Thank you. Jim.

DR. MATHEWS: Very good. We will now present some information to help you assess the adequacy of Medicare payments to inpatient rehabilitation facilities, or IRFs.

IRFs provide intensive physical, occupational, and speech therapy on an inpatient basis. Intensive therapy is generally defined as three or more hours of therapy a day. Medicare payments to IRFs in 2006 were $6.2 billion and Medicare accounts for about 70 percent of IRF patients. A prospective payment system was implemented for IRFs in 2002, pursuant to the BBA.

Prior to that time, Medicare reimbursed IRF services on a cost basis under TEFRA.

Rehabilitation care provided by IRFs is generally regarded as more expensive than in other settings. Because of this, CMS has historically tried to narrow access to IRFs to those patients most likely to benefit from this level of care by means of patient and facility criteria. For

example, patients must need and be able to tolerate and benefit from three hours of rehabilitation services per day.

IRFs must meet a number of conditions, listed here. The most controversial of these criteria is the last one, the so-called 75 percent rule. This rule requires that 75 percent of an IRF's patients, including its non-Medicare patients, must be admitted with specific diagnoses. I've included a list of these conditions in your paper and at the end of these presentation, should you need to refer to it.

While the 75 percent rule has been on the books since 1983, in 2002 CMS ascertained that fewer than 14 percent of IRFs were actually in compliance with it. IRFs out of compliance with the 75 percent rule are paid acute care hospital rates for all Medicare patients. These rates are generally far lower than those under the IRF PPS.

In 2004, CMS issued a new rule reinstating enforcement of the 75 percent rule. This rule is phased in according to the schedule you see here. The 2004 rule also changed some of the patient conditions that IRFs could use to count toward compliance with the 75 percent rule. The most significant change meant that hip and knee replacement patients could no longer be counted. This change had

significant repercussions for IRFs, as I'll show shortly.

To assess the adequacy of Medicare payments for IRFs, we examined the factors listed on this slide, as we do for other providers.

We'll start with the supply of providers. The number of IRFs increased slightly after the PPS was implemented in 2002, at just over about 1.5 percent per year. The number of IRFs has declined very slightly since 2004. Within this small decline, the geographic patterns are the most noteworthy. The number of rural IRFs is increased by over 4 percent annually after the establishment of the PPS in 2002, through 2004. The growth rate in the number of rural IRFs subsequently nearly doubled to 8.2 percent annually on average between 2004 and 2006. This growth is consistent with a 21 percent payment adjustment for rural IRFs under the PPS and the ability of critical access hospitals to have IRF units starting in October of 2004.

A number of urban IRFs and nonprofit IRFs declined during 2004 and 2006, while the number of proprietary IRFs increased slightly.

The number of IRF beds follow similar trends. IRF

beds increased slightly from 2002 to 2004 at just under 2 percent a year. Between 2004 and 2006 the number of IRF beds declined at a somewhat higher rate than the decline in the number of facilities that we saw in the previous slide. This suggests that IRFs are likely reducing capacity over this time rather than completely discontinuing participation in Medicare. Freestanding facilities reduced their number of beds at a somewhat higher rate than provider-based IRFs.

Between 2002 and 2004 both the volume of cases and Medicare spending for IRFs increased rapidly. During this time, length of stay decreased, consistent with expectations under the PPS. From 2004 to 2006, however, the number of IRF cases fell by nearly 10 percent annually. As indicated in your paper, some of this reduction is attributable to the decline in the fee-for-service population as enrollment in Medicare Advantage has increased over this time. However, after accounting for enrollment changes, IRF cases have still dropped by 9 percent a year on average between 2004 and 2006. This decline in volume is the result of the renewed enforcement of the 75 percent rule.

During this time overall spending increased by 1.7 percent annually on average, reflecting both annual payment

updates and the increasing complexity of IRFs' case-mix. Cases that count towards the 75 percent rule are more complex than those that do not. And under the IRF PPS, more complex cases yield higher payments.

So how is the 75 percent rule causing this decline in utilization? One of the conditions targeted by CMS's 2004 revision to the rule was hip and knee replacement. CMS added additional criteria to this condition, making most of these cases ineligible to count towards the 75 percent rule. As a result, the number of IRF hip and knee replacement cases dropped, both in absolute terms and as a share of all IRF cases. Other conditions not included in the 75 percent rule, such as cardiac conditions, also dropped during this period.

By contrast, IRF shares of conditions such as stroke and hip fracture, which the 75 percent rule defines as appropriate for treatment in IRFs, increased from 2004 to 2006.

The drop in the number of IRF cases has raised the question of whether the 75 percent rule is creating an access problem. To evaluate this question, we looked at the 10 acute care hospital discharges that resulted in the

highest admissions to IRFs in 2002, then tracked these cases to see how the admission patterns for these DRGs changed over time. The hip and knee example is illustrative. Here you see a significant decline in hip and knee cases treated in IRFs consistent with that specific policy change of the 75 percent rule that I just mentioned.

During this time the number and share of hip and knee patients seen in SNFs and home health agencies increased, as has the overall number of hip and knee replacement cases. In light of the declines in fee-for-service enrollment over time, on a per capita basis it appears that a greater share of fee-for-service beneficiaries are getting rehab for hip and knee replacements in 2006 than in 2004.

There is a vigorous debate going on at the moment as to whether or not rehab care in settings other than IRFs is of the same quality and cost, and we can discuss this during the Q&A if necessary. At the moment, however, our indicators suggest that beneficiaries' access to rehabilitation services is adequate.

Moving now to assessing the quality of care in IRFs, we use a measure commonly tracked by the IRF industry,

the Functional Independence Measure, or FIM. The scores represent the difference between discharge and admission functioning, as collected in the assessment tool for IRFs. The FIM measures physical and cognitive functioning using 18 items that have a score ranging from one to seven for each measure, with one the highest level of functioning and seven the lowest.

To compare quality on a national basis, we used the average difference in FIM at discharge versus admission for all Medicare patients and for the subset of those patients discharged home. This scores suggest that quality has improved slightly, even from 2006 to 2007. These scores are, however, not adjusted for case-mix, so real quality improvement may be higher than these numbers suggest.

Moving on to our assessment of access to capital: as you saw back on slide six, 80 percent of IRFs are hospital-based. These facilities have access to capital through their parent institution. As you heard in the hospital presentation earlier this afternoon, hospitals' access to capital is quite good.

Freestanding IRFs are in a different position. Roughly half of freestanding IRFs are owned by a single

large chain, which has been experiencing financial difficulties to the extent that it may be having problems generating capital through private investors. The second chain, representing six freestanding IRFs, is in somewhat better financial circumstances but not exceptionally so. The remaining freestanding IRFs are generally single entities or very small chains, so it is difficult to assess their access to capital.

Our final measure of payment adequacy is based on our analysis of payments and costs. After the IRF PPS was implemented in 2002, payments per case increased rapidly. Payments per case continued to rise at a higher rate than costs between 2005 and 2006. Costs started to accelerate in 2004. In 2005 the 75 percent rule into effect and cost per case increased by 10.6 percent, then increased by another 9.1 percent in 2006.

Because of the changes in IRFs' is payments and costs, their margins have varied over time. Under cost-based reimbursement, IRFs' margins were low, roughly 1.5 percent in both 2000 and 2001. Under PPS, margins increased rapidly, peaking at nearly 18 percent in 2003. With the renewed enforcement of the 75 percent rule, and other policy

changes that began in 2004, margins began to decline. We are estimating an IRF margin of 12.4 percent for 2006. While slightly lower than the 2005 margin, the 2006 estimate is still well above IRFs' margins under cost-based reimbursement prior to the implementation of the PPS.

The 12.4 percent margin is at the high end of the range of estimates for the 2006 margin that we made in 2004. IRFs at the 25th percentile had a margin of negative 4.6 six percent while IRFs at the 75 percentile had margins of nearly 20 percent or higher. IRFs in urban areas had margins of 13 percent in 2006, nearly double the margin of rural facilities. Proprietary IRFs have a margin about 60 percent higher than nonprofit IRFs. Lastly, Government IRFs have few Medicare cases and don't operate the same cost constraints as other facilities.

The changes in IRFs' costs and payments in 2006 are consistent with the assumptions we used to project margins last year. We estimated a 10 percent decrease in volume between 2004 and 2005, that 90 percent of the direct patient care cost associated with this drop in volume would disappear, and that there would be no change in IRFs' indirect or overhead costs.

Moving beyond the 2006 margin of 12.4 percent, we are now projecting a margin of 4.4 percent for 208. The 2008 projection assumes an additional 20 percent reduction in cases going to IRFs as a result of the final year of the 75 percent rule phase-in, and makes assumptions about the case-mix corresponding to the remaining IRF cases.

We also assume that IRFs will be able to eliminate 100 percent of patient care costs associated with these foregone admissions but will only be able to eliminate 25 percent of continued overhead costs. If we vary our assumptions on the 75 rule within reasonable parameters, our estimates for IRF's 2008 margin would range between 2.7 and 5.7 percent. Again, the 4.4 percent is our best point estimate at the moment.

To sum up, we see that the supply of IRFs is stable overall but with underlying changes in the availability of IRFs in urban versus rural areas. Volume and spending declined in 2006. Access is difficult to assess. While there have been large declines in IRF volume and large declines are likely to continue into the next year, patients meeting IRF criteria do not seem to be having difficulty obtaining access and patients who no longer count

towards IRFs' compliance with the 75 percent rule do appear to be obtaining rehabilitation care in other settings.

There was a small improvement in quality indicators between 2006 and 2007. IRFs' access to capital is mixed. Access to capital for hospital-based IRFs, representing 80 percent of all IRFs and two-thirds of all IRF beds in 2006 appears to be good. But freestanding IRFs' access to capital is somewhat more tenuous.

Lastly, the estimated margin in 2008 is 4.4 percent. While this is lower than the historical average margin under the IRF PPS of over 14 percent, this is nevertheless higher than the 2.7 percent margin we estimated last year for 2007. As always, we will closely monitor changes in IRF metrics that affect margins in the coming months.

In light of these facts, we are starting our discussions of the update recommendation with the recommendation you made last year for 2008. That is: the Congress should update the payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2009.

The update in law is market basket so the spending

implementation of this recommendation would be a decrease relative to current law. We believe that this update will not have substantial beneficiary or provider implications, given our assessments of beneficiary access and IRF financial performance under the 75 percent rule thus far.

On that note, we will conclude our presentation and stand by to answer any questions you may have.

MR. HACKBARTH: Thank you, Jim. Questions or comments?

MR. EBELER: Thank you, Jim. Just a question when you look at the margins and the potential for changes here, and again thinking about an expectation that providers become more efficient as they move along and become more productive. Did you consider picking no update versus 1 percent?

DR. MATHEWS: Again, this is the straight up recommendation from last year, so we are simply repeating it for purposes of kicking off your discussion.

MR. EBELER: It just strikes me that there's not a compelling reason for 1 percent in this situation.

MR. HACKBARTH: So what's the rest of it? If not 1 percent, what are you advocating?

MR. EBELER: It doesn't seem to me that there's a compelling reason to update in the coming year.

MR. HACKBARTH: Zero, as opposed to one?

MR. EBELER: Yes.

MS. DePARLE: I was interested in the discussion about -- in the paper and today too -- about what happened to the patients who were affected by the changes that occurred as a result of the 75 percent rule, and the hip and knee replacement in particular that you used. You made the point that it didn't mean that people quit getting the hip and knee replacement and needing the rehabilitation. It just meant that they want to other settings, with home health, I guess, being the predominant one but also skilled nursing facilities.

I'd also heard that skilled nursing facilities were aggressively trying to get this population.

And you raised the question, and you've already said you don't have an answer but I just want to highlight this because I think it's a concern, which is what do we know about the quality of care and the resulting outcome after the rehabilitation of these Medicare patients in those other settings?

Honestly, siting here today, I cannot remember why the 75 percent rule was enacted. But presumably the thought was these patients don't -- growth is too high, is usually the place where it starts.

Number two, these patients don't need to be in this setting. And so one would hope that they are now migrating towards a lower cost but higher quality setting. And I think you've already said we don't know. I'd be interested, if there's any data that we can look at, to try to figure exactly what is happening.

DR. MATHEWS: The short answer to the question is no. We have tried to do this on a limited basis in the past. A couple of years back we commissioned RAND to look at differences in cost and quality of care for hip and knee patients and we found that the cost was somewhat higher in IRFs but that the outcomes in IRFs were also better than what was obtained in SNFs. But again, very severe methodological difficulties needed to be overcome in order to achieve those results.

We don't have a common risk adjuster to fully know whether we are comparing like patients, and we do not have a common patient assessment instrument across the multiple

post-acute care settings to be able to accurately compare outcomes. So until 2011, at the earliest, this is going to continue to be a heavy lift.

MS. DePARLE: And we've made this recommendation before but maybe we need another one about all of that because it does seem -- it's an area of concern, I think.

MR. HACKBARTH: So as I recall the RAND work, as you say, it was handicapped by the lack of common measures for assessing patients and measuring outcomes. And my recollection was that a theory as to why the IRFs had higher cost but also higher quality was that there was, in fact, an unmeasured difference in the patients, and the patients that were most able to undergo aggressive therapy were systematically put in the IRFs, whereas the patients that were more frail and not able to handle the therapy were -- tended to be put into the nursing homes.

DR. MATHEWS: That is correct. Also, if I recall correctly, the RAND study showed that patients who were discharged to SNFs rather than IRFs were older, on average, which would be consistent with more frail.

Also, within the last couple of weeks, I believe, the RehabCare Group came out with a study comparing limited

outcomes measures, basically length of stay and percent discharge to home, between IRF and SNF care that also showed these same age differences across the populations.

So I think there probably is some population sorting out here that we cannot accurately fully assess yet.

MR. HACKBARTH: Which, as you say, again just highlights once again the importance of the work that is now being launched to systematically, more systematically, try to compare the care rendered by different types of post-acute providers for similar patients. And that's important work and thankfully it seems to be starting to gear up, although we won't have results for quite a while.

DR. MILLER: One other thing on this is on sort of differences between settings and better and worse. Way back, before we even did the RAND thing, we put together a set of clinicians when the 75 percent rule was coming online to talk to people.

I want to be really clear about this. Most of the clinicians who were associated with an IRF were talking about necessary it was and what they did. There was one clinician who said I don't really have these in my area or enough to make it really worth my trouble. And what I've

done is I've developed these protocols where when people are going to hip and knee replacement they have to go through exercises before they do the surgery to kind of build up the area and to actually -- I'm not clinical, obviously -- just in case you weren't clear on that.

[Laughter.]

DR. REISCHAUER: [Inaudible.]

DR. MILLER: Oh no, your appointment is still on.

But that would build up the patient so that their recovery is actually better after the fact. And then he had a whole home health network set up of rehab that went on after the fact.

His point was if you do this kind of differently, you can take a lot of these specific hip and knee replacements that were in question and actually get a decent outcome with them. But one guy, one clinician, just to be clear.

DR. DEAN: I was going to say, in addition to that have been technological change. I think everything that Mark said is true. And also, some of these procedures are less invasive than they used to be. And so I think actually it's a moving target. I think these people come out of

surgery healthier than they did 10 years ago.

MR. HACKBARTH: Other questions and comments on IRFs? I think we've reached the point where people are wearing out. We need some rehabilitation before we can go further.

Remind us, Jim, they projected a margin last year when we were doing this was --

DR. MATHEWS: Last year, for 2007, we had a projection of 2.7 percent with a range of 0.5 to 5.5.

DR. KANE: [Inaudible.]

DR. MATHEWS: That's correct.

DR. KANE: And we're predicting higher profit margins.

DR. MATHEWS: That's correct.

DR. KANE: When we recommended the 1 percent, IS THAT what they got? Or did they get a full update? You said update in 2007.

MR. HACKBARTH: I think Craig --

MR. LISK: They got something slightly less -- with the policy changes that were in effect, they got something slightly less than market basket. Their projected payment increase is about 2.4 percent. I'm sorry, no.

Actually in -- we're making an update recommendation for 2008. They got about 2.4 percent payment increase with the policy changes, all the policy changes put in place. That's not counting any impact of the 75 percent rule, per se. But in terms of payment increase it was 2.4 percent in 2008.

DR. KANE: So our recommendation was 1 percent. They got better than what we recommended?

MR. LISK: Yes.

DR. KANE: And this time they might, too.

DR. REISCHAUER: The update was market basket and then policy things brought it down to 2.4 --

MR. LISK: That's correct. The net effect was the 2.4 percent payment increase.

DR. KANE: But they went ahead and gave them the full market basket even though we said -- so they ignored us.

MR. HACKBARTH: Anybody else?

MR. EBELER: Is it only rookie commissioners who are foolish enough to lower the update, the recommendation?

DR. KANE: No, I did that the first year.

MR. EBELER: But it's just that you only do it your first year?

DR. KANE: After that you stop caring.

MR. DURENBERGER: You're just a straight man for the rest of us, Jack.

[Laughter.]

MR. HACKBARTH: Thank you very much, and we'll think about putting you earlier in the queue next time, if you bribe the Chairman.

DR. MATHEWS: This is fine.

[Laughter.]

MR. HACKBARTH: Now we will conclude with our public comment period. Please identify yourself, as step one. And keep your comments to no more than a couple of minutes. When you see the red light come on, that's when I'm thinking about your ending, even if you're not.

MR. KALMAN: I just have a few brief, hopefully cogent points, I would like to make.

First of all, I am Ed Kalman. I'm general counsel for the National Association of Long-Term Care Hospitals.

We made an attempt at modeling margins this year, projecting them. Our number was 4.7. The number expressed to you was 4.8. So we're quite close.

The distribution of that number is rather

interesting. What concerns me is that we're projecting the margin in rural areas will be a negative 7.28. So you have long-term care hospitals which are projected to the lowest margin of any class of providers, and we have very serious and significant issues on urban versus rural, and on small versus big, according to our data.

We also have current policy that CMS regulations which require a one-time adjustment to the standard amount this year in order to achieve budget neutrality for the standard amount in the first year because we have better data now.

I can't conceive that that's going to be a positive number.

So we're talking about an industry that has about double the negative margins of any other industry, especially in rural areas. And I hope you consider that over the next month.

With regard to some of the other issues, I would like to point out that the MedPAC study in 2004, in addition to determining that Medicare spending for appropriate patients was not different over an episode of care from areas where there are and are not long-term care hospitals,

found that the readmit rate for acute hospitals was 26 percent less.

And I do believe that CMS, through its contractor, is trying to replicate that study with more recent data and look forward to seeing it in the report, which should be a phase three of the RTI report.

Finally, my third cogent point is that the CHAMP bill largely mirrors recommendations of MedPAC, in addition to encouraging the development of criteria. The legislation contains a moratorium on new long-term care hospitals and beds for a four-year period, which is intentionally aligned to the uniform assessment tool, that is in 2011. So the idea is a period of peace or stability as a matter of regulatory matters and the development of criteria to come in with a reasonable time.

Additionally, the legislation calls upon CMS to use existing tools to address the substitution of service issue by requiring a very significant intensification of medical necessity review. Not only on admission, but continued stay. The idea being a patient that's admitted to a long-term care hospital that is no longer at a hospital level shortly after they are admitted is probably a case

that should have stated in the acute hospital. And review entities are able to tell the difference between patients at an acute and SNF level of care.

So the legislation does the best with what we have to address the problems and, remarkably, it was this Commission that recommended intensified review.

Thank you.

MS. COYLE: Good afternoon. I'm Carmela Coyle with the American Hospital Association. Thank you for your discussion. Three thoughts for the Commission's consideration, please.

First with regard to the Medicare inpatient PPS discussion and update, and that is that Medicare margins are again negative. Based on our data, we have reached a 10 year low. We have two-thirds of hospitals losing money treating Medicare patients.

Costs, however, are growing at a lower rate of increase than they have in the last couple of years, which means they're moving in the right direction.

But even with cost growth slowing and full market basket increases for the last three years, we still have increasingly negative Medicare margins. The data that

you've just seen shows a negative 3 percent margin in 2004 and 2005, a negative 4.8 percent in 2006, negative 5.4 in 2007, and your projections in 2007 and 2008 a negative 4.5 in 2008.

I think it's challenging to tell the story that suggests that given these statistics, payments in this particular area are adequate. So we would strongly urge the Commission to recommend a full market basket update for fiscal year 2009.

Second, on the issue of productivity as a "staying in business" issue, we'd like to suggest that it is a "staying in business" issue. We've got one in four hospitals losing money overall, losses in Medicare, losses in Medicaid, losses in many market areas given private sector insurance coverage. Even MedPAC's own analysis shows that if you remove those high-cost providers, it still results in negative Medicare margins. These hospitals have an incentive. It's called getting off the financial brink to be more productive to improve their efficiency.

I would suggest that using Medicare market basket update policy to really try to affect productivity across the board may be an overly simplistic and even a ham-fisted

approach to trying to adjust for this.

I would urge the Commission not to cut the market basket update for every hospital in an effort to try to increase productivity for a certain group of hospitals.

And finally, similarly, a reduction in the current indirect medical education adjustment really does ignore the bigger picture. That change would really do nothing more than remove payment overall from teaching hospitals, those -- as you well know -- that are the least financially viable overall and those who are most vulnerable.

And while reducing that indirect medical education may help all of us make sense of a series of regression analyses, we don't believe that it addresses the broader and real question of payment adequacy. So again, would ask you and urge you to keep that recommendation where it is today in current law.

Thank you.

MS. GAGE: Hi, Barbara Gage with RTI.

Several studies kept coming up during the long-term hospital discussion, so I thought that I would just answer a few of the questions.

The biggest issue with the long-term care

hospitals, as many of you probably know, we've been working on this issue for CMS for several years now. And the work has included analysis of the Medicare claims, looking at the differences in the costs and the outcomes of the more medically intensive populations using claims data. And as you know from the presentations that have been given on post-acute care and the demonstrations that are underway, the claims data are very limited in terms of allowing you to look at the severity of illness within the diagnoses.

So we've used different groupers, the APR-DRG group, the HCC measures that are used to measure the past year expenditures, trying to look at some of these differences and the case-mix complexity keeps coming back because, as we found in a recent analysis that Dana referred to that updated some of the work that yourselves had done a few years ago, there is a -- LTCHs serve a very important role in the health care delivery system for the critically ill populations, as we've heard repeatedly from the pulmonologists involved in the studies as well as other participants.

But as MedPAC found several years ago, the differences in costs and outcomes are only for that more

intensively subset of ventilator patients. We used propensity score analysis methods to match patients within areas that have LTCHs to look at the difference in the population that was treated at an LTCH versus the one that didn't broke our populations into three different groups in terms of how likely they would be to use it an LTCH, much of which was related -- as some of our earlier work showed -- to longer ICU length of stay prior to the LTCH admission. So again, a proxy of that severely ill population, as well as longer time on a ventilator and things that you would expect.

And so for that more intensive population, there are very important differences in lengths of stays, outcomes, and 60 day mortalities, the cost to the Medicare program. But that same finding wasn't there with the less intensive ventilator cases, suggesting again the importance of a better case-mix measure before really having solid criteria.

We have had a couple of technical expert panels, which Dana mentioned were very useful in that we had physicians from each of the different levels of care that treat these severely ill populations, exchanging and

defining how you'll recognize this type of patient, what types of physiological factors, what types of resources. And the technical expert panel really -- there was consensus that yes, you can identify the critically ill patients and we need to have further discussion about that definition of the patients but that they are treated in acute hospitals, in the post-ICU setting, the step down units. They're treated in the LTCHs. There are a few souped-up SNFs, as they were referred to during the TEP, that can treat them. It's not a typical environment to be treating such an intensive ill patient.

So there's a lot of work yet to be done to better refine that definition but we will be working on that during the coming year.

MR. HACKBARTH: Okay, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:46 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, December 7, 2007.]

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, 2007
8:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: This morning we'll continue our payment adequacy discussion and begin with physicians. John?

MR. RICHARDSON: Good morning. My colleagues and I would like to present our analysis of Medicare physician payment adequacy and a draft recommendation for how the Medicare physician fee schedule conversion factor should be updated in 2009.

Our presentation will cover the areas outlined on this slide. First, we would like to provide an update on the status of CMS's current efforts to update the data used in calculating the practice expense component of the physician payment system. Practice expense reimbursement comprises almost half of Medicare's $60 billion in physician fee schedule payments, and therefore is a key component of physician payment adequacy and accuracy.

Next, as we do every year, we will evaluate several indicators to assess physician payment adequacy, which are listed on the slide in the middle. Please note that one key indicator we look at each year, which is a comparison of average physician payment rates paid by

Medicare and the average rates paid by two large national private insurers, was not ready in time for this morning's meeting but we will be able to present that to you in January for your consideration at the January meeting.

After looking at the payment adequacy indicators, we will review projected input cost increases and productivity changes applicable to physician services in 2009, and then present a draft recommendation.

Last, we also would like to highlight several areas of further analysis on physician payment policy in which we are engaged and will continue focusing on in the coming year.

Now Ariel will discuss the status of and our concerns about the current physician practice expense data collection effort.

MR. WINTER: There are three types of physician RVUs, as you probably remember: the work, the practice expense, and professional liability insurance. Practice expense accounts for almost half of physician payments.

There are two components to the practice expense. There are indirect costs and direct costs. The direct PE covers the cost of medical equipment, medical supplies, and

non-physician clinical staff. The indirect PE covers the cost of office rent, utilities, and administrative staff.

CMS uses cost data from surveys of physician practices to calculate the indirect PE RVUs. For most specialties, CMS uses cost data that was collected by the AMA between 1995 and 1999. However, for 13 specialties, CMS uses more recent cost data collected by those specialties in supplemental surveys. The use of more recent cost data for these specialties increases their hourly practice costs relative to all other specialties, and therefore increases the RVUs for the services they perform.

The Commission has stated that CMS needs up-to-date practice cost data for all specialties to calculate accurate PE RVUs.

The AMA and the specialty societies fielded a new practice cost survey beginning in April of this year. CMS has agreed to purchase the data and will consider using it to update the PE RVUs. This survey effort has been discussed at recent RUC meetings. The new survey initially targeted a 50 percent response rate and the AMA planned to survey providers until the end of 2007. As of September, however, the survey had achieved a 5 percent response rate.

In response, the AMA has retooled the survey to increase the response rate. They have extended the field period through 2008, which means that at the earliest data would be available to CMS in 2009 for the 2010 fee scheduled. They've also eliminated questions to make the survey shorter.

The AMA has also set new targets for the retooled survey. The new goals are to achieve a 20 percent response rate and collect about 100 completed surveys per specialty and to meet the precision criteria set by CMS for the supplemental surveys. We are hopeful that the AMA survey can meet its new targets. However, if the new targets cannot be met, policy makers may have to consider other options to collect updated cost data. Even if the targets are met, there may be questions about the survey's representativeness because it is targeting a fairly low response rate.

There are two options I want to briefly mention here. We will be talking about this issue in more detail in the future. The first idea is to use an existing survey to validate the AMA's survey results. Examples could include the specialty-specific supplemental surveys that were

conducted over the last several years or the Medical Group Management Association's annual practice cost survey.

A second idea is if the AMA survey does not succeed, whether we should consider requiring providers to submit cost data, whether a sample of practices or all practices.

And now I'll turn things back over to John.

MR. RICHARDSON: Thank you. We will look at several indicators of payment adequacy for physician services. First is a beneficiary reported access measure.

Each year, MedPAC sponsors a telephone survey to obtain the most current data possible on beneficiary access to physician services. This year's survey was fielded just this past August and September. The survey includes a nationally representative sample of Medicare beneficiaries aged 65 and over and also a sample of privately insured persons aged 50 to 64 to serve as a comparison group. The survey includes about 2,000 individuals in each group.

It is important to note that the survey sample includes both fee-for-service and managed care enrollees due to the difficulty in getting reliable self-reported information from beneficiaries on their enrollment status.

This means that the results we are about to look at come from beneficiaries' experience in fee-for-service Medicare and Medicare Advantage in the case of the Medicare beneficiaries.

This year's survey found that in 2007, as in the two prior years, most Medicare beneficiaries and privately insured individuals do not experience delays in getting access to routine care, nor in cases where they need to see a physician for treatment of illness or injury.

When comparing results between the two groups, we see that Medicare beneficiaries reported better access on both of these measures compared to the privately insured group with statistically significant differences between the never and sometimes results for the two groups.

The survey also asked respondents if they sought a new physician during the past year, and for the subset of those answering yes to this question whether they experienced any problems in finding a new physician. The survey asked specifically about respondents' experiences finding a primary care physician and a specialist.

To put the results presented in this slide in perspective, it is important to understand that relatively

small percentages of the two samples report seeking a new physician each year. About 10 percent or about 200 individuals in each group reported looking for a new primary care physician and about 15 percent or about 300 individuals in each group reported looking for a new specialist.

These small numbers of surveyed individuals mean that the differences we see between years and between the two groups often do not have statistical significance, making it more likely that the differences are due to random variation rather than real differences in the group's experiences.

Looking at the table and focusing first on the Medicare beneficiary responses, we see that 70 percent of Medicare beneficiaries reported no problem finding a new primary care physician in 2007 compared with 76 percent reporting no problem in 2006. The difference between the 2006 and 2007 results was not statistically significant. There also were slight increases from 2006 to 2007 in the even smaller percentage of beneficiaries who reported small or big problems, but again the year-to-year differences are not statistically significant.

Among those looking for a new specialist, the

percentage of Medicare beneficiaries reporting no problem actually increased a bit from 2006 to 2007, and those reporting small or big problems decreased, again with no statistical significance between the 2006 and 2007 values.

Privately insured group seeking a new primary care physician reported somewhat fewer problems than the Medicare group in finding one, and in this instance the difference between the two groups in 2007 was statistically significant. On the other hand, the privately insured group seemed to report more problems finding a new specialist than their Medicare counterparts in 2007, though here again the differences are not statistically significant.

In assessing access to physician services, we also examine what physicians report about their willingness to see new Medicare patients. Here the most recent data we have are from 2006. One source we consult is the National Ambulatory Medical Care Survey, or NAMCS, which is fielded annually by the National Center for Health Statistics. NAMCS is a detailed survey of a nationally representative sample that represents approximately 300,000 office-based physicians engaged in patient care. The results of the 2006 NAMCS showed that about 80 percent of all physicians

surveyed are accepting any new Medicare patients, which is the same rate as for non-capitated private pay patients. Only self-pay patients had a higher rate of acceptance, which was about 88 percent.

We also look at physicians that rely on Medicare for 10 percent or more of their total practice revenue and among this group the new Medicare patient acceptance rate was 93 percent.

It's also important to note that both of these rates for all physicians and the physicians that have more than 10 percent of their revenue from Medicare, those rates have remained stable from 2004 to 2006.

You may recall that MedPAC's March 2007 Report to Congress also contain the results of a survey of physicians which was sponsored by MedPAC in 2006. Reassuringly, the results from the 2006 NAMCS are very similar to those found by our survey last year. We also, in the NAMCS results for 2006, looked at the results broken down by specialty type; that is by primary care and all other specialties. And similar to the MedPAC result in 2006, we found that a slightly smaller percentage of primary care physicians and specialists reported accepting new Medicare patients.

However, in the 2006 NAMCS, those rates were 90 percent for primary care physicians and 95 percent for specialists.

Another indicator we examined to assess the supply of physicians who are willing to treat Medicare patients is whether the number of individual physicians actually billing Medicare is growing from year to year at a rate that at least keeps up with the growth in the total Medicare population. In the analysis shown here, which uses 100 percent of paid claims data, we count individual physicians who saw at least 15 unique Medicare patients in each year and then calculate a ratio of the number of those physicians per 1,000 beneficiaries enrolled that year.

As shown, the supply of physicians billing the program in 2006 was essentially the same as in the previous five years.

We also performed the analysis looking at physicians with larger Medicare caseload thresholds with essentially the same results, 2006 looking very similar or the same as the previous five years.

In summary, our analysis of beneficiary access to physician services finds that access for most beneficiaries remains good, both for beneficiaries accessing their current

physicians and for those seeking new physicians. However, there also appear to be pockets of some constrained access, which we will continue to analyze and propose policy options to address over the coming year.

I will return to look at some of these policy options that we're working at the end of the presentation.

Next, Kevin will present the results of our analysis of recent changes in the volume of physician services.

DR. HAYES: Thanks, John.

For our next indicator of payment adequacy, we used physician claims data and analyzed the volume of physician services with volume here including both the number of services and their complexity or intensity as measured by the physician fee schedule's relative value units.

The data show that use of physician services continued to grow in 2006. Across all services, volume grew at a rate of 3.6 percent per beneficiary. Among the broad category of services shown here -- evaluation and management, major procedures, and so on -- volume growth rates varied but all were positive.

Across the board, volume grew somewhat less rapidly in 2006 than in previous years. For instance, the all-services average for 2001 to 2005 was 5.1 percent compared to the 3.6 percent growth rate for 2005 to 2006.

Imaging and tests were the categories with the highest 2006 growth rates at 6.2 percent and 6.9 percent respectively.

Looking at more detailed types of services, we see a few instances of decreases in volume such as coronary artery bypass grafts, but they were usually explained by substitution of one service for another.

Let me also draw your attention to the type of service called other procedures, where we see what looks like lower growth in 2006 compared to previous years. This procedure category includes outpatient rehabilitation. The volume of outpatient rehabilitation, considered by itself, fell by 13 percent in 2006. Annual spending limits for these services -- spending limits known as the therapy caps -- went into effect on January 1st of that year.

The decrease in outpatient rehabilitation was large enough to affect growth rates for broader categories of services. For instance, in 2006, volume growth for all

services was 3.6 percent on average, including outpatient rehabilitation, but 4.1 percent otherwise. Looking at the other procedures category, volume growth was 2.6 percent with outpatient rehabilitation but 4.6 percent without.

Before we move on to the other indicators of payment adequacy, we'd like to pause here and recall that there are different ways to look at the volume of physician services. In addition to analyzing volume growth as part of our framework for assessing payment adequacy, the Commission has identified rapid volume growth as a sign that some services in the physician fee schedule may be misvalued. We have also considered the volume of services from the perspective of geographic variation, doing so through in-house work and the work of John Wennberg, Elliott Fisher, and others at Dartmouth. While the Commission has addressed these issues in previous reports, there may be a need to address them again in the March 2008 report.

On the point about rapid growth as a sign that some services may be misvalued, we see here that some services are growing very rapidly. This list and the longer one in the chapter draft, include services with allowed charges of at least $10 million in 2001.

Note also that work RVUs for such services often have not been reviewed recently. For the services shown here, there has been no review since of the services first appeared in the fee schedule. As discussed in the Commission's March 2006 report, simultaneous with rapid volume growth it is possible that there are processes -- process such as learning by doing, work process reengineering, and substitution of nonphysician for physician inputs -- that are either making this rapid growth possible or that are at least accompanying it.

The Commission's recommendation is that the Secretary should establish an expert panel that would collect data, develop evidence, and otherwise help CMS identify services that may be overvalued. In consultation with the panel, the Secretary should initiate the five-year review of services that have experienced substantial changes in volume, site of service, and other factors that may indicate changes in physician work.

On the issue of geographic variation, recall that Elliott Fisher himself was here in November of 2006 and gave a presentation that address what he now calls "the paradox of plenty." In regions with high service use, quality of

care was found to be no better, and some measures appears to be worse than lower service use areas. Also, patient satisfaction with care was not found to be better in high service use areas.

The Commission, for its part, has interpreted these findings as suggesting that the nation could spend less on health care without sacrificing quality, if physicians with a more resource intensive practice style reduced the intensity of their practice. The Commission's recommendation is that the Secretary use Medicare claims data to measure physicians' resource use and share the results with physicians confidentially.

With this recommendation, one option is to link it to the update for physician services. In other words, you may want to make an update recommendation and at the same time make a recommendation about progress toward measuring resource use and providing physicians with feedback. In a few minutes, John will go over a recommendation drafted along these lines, but first he will continue the presentation and discuss another set of indicators of payment adequacy, indicators on the quality of ambulatory care. John.

MR. RICHARDSON: Thank you, Kevin.

To assess changes in the quality of ambulatory care that physicians render to Medicare beneficiaries, we examined a claims-based performance measure set called the Medicare Ambulatory Care Indicators for the Elderly, or MACIEs. The MACIEs are derived from the Access to Care for the Elderly Project indicators that were developed by RAND for the Physician Payment Review Commission in 1995. The MACIEs are updated measures intended to reflect basic clinical standards of care for common medical diagnoses among the aged Medicare population.

The MACIEs include two types of measures: 32 of them examined the percentage of beneficiaries who received clinically appropriate care for their diagnosis, for example the percentage of those with a reported diagnosis of diabetes that received hemoglobin A1C testing within the measurement year. Six other MACIEs indicators measure the rate of potentially avoidable hospitalizations that are directly related to a beneficiaries' diagnosis such as heart failure or complications from diabetes.

This table summarizes the direction of the changes in the 38 MACIEs indicators that we track using a 5 percent

sample of claims data from 2004 to 2006. The numbers in the table refer to the number of indicators within each medical condition that improved, were stable, or worsened.

As you can see, 32 of the 38 measures improved or were stable over the period studied. Six indicators, all related to the delivery of clinically appropriate care, worsened, including three related to cancer care and one each for diabetes, CHF, and COPD. I just very briefly wanted to touch on those six indicators.

The decreases in the diabetes and COPD indicators were very small declines off of very high percentages, on the order of 1 or 2 percentage point drops off of 97 to 98 percent performance rates. Two of the cancer care indicators and the CHF indicator that worsened involve a slightly lower rate of the use of certain imaging procedures for beneficiaries with breast cancer or heart failure diagnosis. And the remaining cancer care indicator shows slightly lower rates of testing for colorectal cancer within a diagnosis of anemia.

In addition to looking at the direction of changes in all 38 indicators, we also look at the overall level of performance within the 32 process measures based on the

premise that the measures reflect a basic standard of care that almost all Medicare beneficiaries should receive. All Medicare beneficiaries, that is, with a qualifying diagnosis, of course.

This year's analysis found that for nine of the 32 process measures, fewer than two-thirds of beneficiaries for whom the procedures were indicated received them. That's nine out of 32, fewer than two-thirds received them.

Now for the final section, we'll turn to the final part of the payment adequacy framework, which is looking at forecasted changes in costs for 2009. CMS's preliminary forecast of input price inflation for physician services in 2009 is 2.7 percent. This figure reflects separate rates of input price increases for the two major components of physician services: physician work, or the net income and fringe benefits received by physicians; and physician practice expense, such as practice employee's salaries and benefits, drugs and supplies, and professional liability insurance costs.

The input price factor shown here is not adjusted for expected productivity increases. We separately calculate a productivity adjustment to be used across

provider sectors based on the most recent 10-year rolling average of multifactor productivity changes reported by the Bureau of Labor Statistics. As we discussed yesterday during the hospital presentation, our current estimate of the target productivity factor is 1.5 percent.

In light of the payment adequacy analysis we've performed, which of course does not reflect the pending 10 percent reduction in physician payment rates scheduled to take effect in January under current law absent Congressional action, we present for the Commission's consideration a recommendation which is the same as last year's calling on the Congress to update Medicare payments for physician services in 2009 by the projected change in input prices less the Commission's expectation of productivity growth. Based on our current estimates, presented in the previous slide, this recommendation would result in an update of 1.2 percent.

As Kevin discussed earlier, we also propose that the Commission consider recommending enactment of legislation that would require CMS to establish a process for measuring and reporting individual physician resource use on a confidential basis to each physician. This

proposed recommendation is similar to one approved by the Commission in the March 2005 Report to Congress.

As for spending implications, since current law calls for a negative update of about 5 percent in 2009, enactment of the proposed recommendation would increase Medicare spending and it would increase beneficiaries' cost sharing relative to current law in the form of higher Part B premiums and higher coinsurance payments for each covered physician service.

If the recommendation for physician resource use was also enacted, there could be increased discretionary spending if CMS were given additional resources to carry out these functions. However, we believe the proposed recommendation is more likely to maintain current levels of access to physician services than the negative update called for under current law.

In conclusion, I would like to present a couple of ideas that we are working on, other areas of physician payment. We would like to be clear that our proposed recommendation does not reflect satisfaction with the status quo of Medicare physician payment policy. We are particularly concerned about limitations in the current

payment system that inhibit access to primary care services. This slide outlines several policy areas related to primary care access in which we are already engaged in analysis and we'll be presenting more information about our work plan in these areas at the January meeting.

That concludes our presentation and we look forward to your discussion. Thank you.

MR. HACKBARTH: Questions, comments?

DR. BORMAN: This is, as always, a very nice analysis and very helpful. I think, as I look at going forward, because I think we all want to know where we're trying to get to and how we can more rapidly get there, there are several issues or several pieces of this multipart area that come to mind. You've touched on them mostly here toward the end.

I would suggest that next to the bottom alternative methods of calculating work RVUs might be broadened to a bigger consideration of an alternative method of relative valuation generally, rather than the work RVUs per se. I think one of the places that we've gotten to is a formula with an awful lot of moving parts and it makes it difficult to understand. It makes the endpoint results of

changes in the parts difficult to predict. It makes it very difficult to induce stability in a system in which you wish to make broader strategic changes because all of these subset parts are in continuous motion.

So I think that some work toward thinking about, in a very creative way, would be what are other ways that we can find to determine what the true costs for practitioners may be, help them meet the costs of the efficient practitioner, and then figure out how we onlay over that whatever else is beyond those hopefully measurable direct sorts of expenses.

I think one of the difficulties that we have with the current system is the enormous shift that has gone on from hospital-based care to ambulatory care. And we have a system the underpinnings of which really generate from the mid-to-late 1970s and early 1980s and a huge change in our pattern of care delivery in terms of site of service has gone on. And as things, expensive things with expensive equipment, have moved to the outpatient arena, it has materially distorted this system.

So I think we either need creative ways to reallocate or my personal preference, as is obvious, is a

simpler, more overriding approach to this.

So I would just say that alternative methods of calculating work RVUs, to me, is a relatively narrow approach to this and I would like to see us go a little bit bigger.

I think maybe Arnie wants to talk to that particular point. I do have one other thing.

The other piece of it, two pieces. Briefly, I think as we go forward it probably is time to start to flesh out in somewhat concrete terms what the medical home and care coordination services really will be. I think we all have a sense that this is an opportunity to have better management of the resources that we're expending.

I will say that in my last several years on the CPT Editorial Panel, we had an enormous volume of proposals come forward for various things labeled care management, multidisciplinary teaming, just all kinds of things. But when we got down to trying to get a definition that folks could agree on, not necessarily what you do from 9:00 to 9:05 in the morning, but a sense of what are the criteria by which someone could can come and say this service was indeed delivered, it fell apart.

And so I know that ACP and a number of organizations are much further down the road in their thinking, but I would like to start to see some a little more specific description to this.

And then finally, I do think the workforce is an issue regardless of what we think, regardless of what the Congress does, regardless of the time that it takes to get there, things are already happening in the medical student and resident marketplace where this train has left the station to some degree.

If you look at, for example, the AAMC exit questionnaire for graduating fourth-year medical students for 2007, in almost every specialty where they ask, where they differentiate primary certification from subspecialties -- pediatrics, internal medicine, OB/GYN -- OB/GYN is the only one of those where the subspecialist planned number of students does not exceed the primary certificate. So you've got people in the marketplace that are already planning to a more subspecialist dominated care, which may drive the workforce more towards a mix of physician extenders and subspecialists.

But stuff is happening, and I think that our

process to change is going to find that by the time we can get to material change, a lot of it will have been done for us. So I think we have to keep tabs on the workforce.

Thanks.

MR. HACKBARTH: I share your concern, Karen, about the long-term path that we're on. I agree with your premise that there have been, over time, important shifts in site of service and they're likely to continue. We have difficulty getting not just accurate data but almost any data to update elements of the current structure.

I apologize, I was trying to organize my own thoughts. I missed the directions that you want to pursue as alternatives to this. What's your sense about if we don't do this, what? What's the alternative for that longer term to circumvent the problems that you've identified?

DR. BORMAN: I think certainly some things are directions that the Commission has previously outlined in the sense of enabling physician or facility partnerships with gainsharing and looking at bigger bundles. I think bigger bundles not just for inpatient delivered services but outpatient, including E&M services. So I think thinking of it in those terms, and I think the Commission has a lot of

work on that.

I think some other things, you know, is there some variation of cost reporting, for example, that could get us away or perhaps become more accurate than this survey PE estimate data. I was part of some of the refinement panels after the CPAPs in the late 1990s. The notion that we're going to bring more precision to something, a process that's inherently precise, I think is really just incredible to me.

So I do think stepping back and saying do we have other ways of figuring out what are the legitimate costs of an efficient provider and then building a system that incorporates that and allows maybe something else that relate to your quality efficiency of resource use might be another method.

But I think the bigger bundling thing, I think probably is where I'm headed.

DR. CASTELLANOS: My concerns are similar to Karen's. I'd like to get a little more practical. Could you get on slide 14 for a second?

This is an issue that we looked at -- in fact, I had the MedPAC staff look at this last year. And Kevin did a really good job on this.

If you remember, one of the things we saw last year was by specialty which specialty really had highest growth in services? The highest was emergency room, which I think we can all expect perhaps because of access to care. The next one was urology. Urology only accounts for 2 percent of physicians. Myself being a urologist, I was very interested in that.

So Kevin did a study and we identified what it was and we saw it was prostatic microwave therapy. The question is what to do with that now?

At my suggestion, and talking to Kevin and Mark Miller, we thought it was very important to at least identify what we did and then show it to the specialty to see what the specialty would do with this. And quite honestly, we did. And urology was somewhat surprised about that and has looked into it and has made some very appropriate recommendations in direction for education.

I think this is -- one of the recommendations that MedPAC had was to identify the individual practitioner but I would also suggest that perhaps we also identify the specialty organization so that specialty organization can provide some insight into that.

As part of the insight into that, they looked at it very carefully. I don't have their final recommendations but one of the things that you have to consider when you have increased growth is that we're replacing a major surgical procedure in the hospital with significant complications to an outpatient minimally invasive procedure.

And there is a lot of patient choice to that. It's not as simple as we're just doing more of that, there's a lot of reasons. And that's why I say it's really important to send that back to the society and let them look at it. There's questions of how productivity was calculated, et cetera. But the point I have is that I think, as MedPAC, we should make that recommendation also to the society.

I wonder if you could go to the one where the crack in the wall that we see with access to care? And Karen kind of said this the same way that I did it, that I think we are going to have a problem with the baby boomers coming and the workforce.

MR. RICHARDSON: Was it for new physicians?

DR. CASTELLANOS: The last one, right there.

As you can see, the real problem here is getting a

new physician. And with the advent of the baby boomers coming in in 2010, that's going to get greater. The primary care doctor being the baby boomer himself -- and in Florida 55 percent of the primary care doctors are 55 years or older. So that's a real significant problem. We do deal need to do with the workforce problem.

But I think that's a crack in the wall. To say that most people don't have a problem is correct. But if you're one of that 30 percent that are having a problem or 30 percent of 45 million being about maybe 12 or 13 million people, that's a significant number not to just push under the rug. But I think it needs to be addressed, that we do have an access problem and it's going to get worse.

There are a couple of other issues that I have. One was on productivity. Again, you're going to have to educate me and I'm asking you a question. I thought in a physician community, the productivity was automatically detected in the MEI as opposed to the other Medicare providers that it suggested.

MR. RICHARDSON: It is when the CMS publishes the final rule for the update. They also make a productivity adjustment.

What we're showing here is basically just the two pieces, the input price inflation figure here of 2.7 percent which will be updated in January for the final estimate we get from CMS, comes from CMS's estimates. We also make a productivity growth adjustment. We calculate it in a way similar to CMS's but slightly differently. But it's methodologically the same, the same approach.

MR. HACKBARTH: It's not double counted. There's not double counting.

MR. RICHARDSON: The 2.7 there does not include a productivity --

DR. CASTELLANOS: It's not double counted, but again I think that the physician community is the only one that it is automatically impacted on in the MEI while the other Medicare providers it's recommended by our recommendations.

Thank you.

DR. MILLER: Just a real quick marker. Karen, I'd like to catch you offline with Cristina, John, and Kevin. To the extent you can talk about it, the statement about the CPT process, of being unable to define coordinated care. We're doing a whole bunch of work in the background trying

to grapple with the same question. And so we'd like to have a conversation if we could.

DR. SCANLON: Just a clarification. The 30 percent that are having trouble finding a new physician is not 30 percent of Medicare beneficiaries but 30 percent of those seeking a new physician, if I understand that two tables.

MR. RICHARDSON: That's correct.

DR. SCANLON: So it's more like 3 percent of Medicare beneficiaries. It's still a big number but different than the 30 percent.

MR. RICHARDSON: It's 30 percent of 10 percent.

DR. REISCHAUER: A couple of elaboration on Ron's point. One is he suggested for one of these procedures that had grown very fast that there was a substitute, in some sense, for a more complex invasive inpatient procedure. And it would be nice when we see those to see whether there's been a marked decline in some related or some substitute kind of procedure. We've seen a lot of that in the cardiac care area over the last 10 years.

And it sort of strikes me there's two classes of things. There's that new thing which is not a substitute

for something that allows us to do a new condition and how you would evaluate rapid growth in that area might be different than one which is substituting for something that was already in existence.

DR. CASTELLANOS: May I comment to that? That data is available and I have it with me. That's why it's important to show it to the society because they've look at this data. I can show you that data and I'll provide it to Kevin today, showing that the major invasive procedure has definitely decreased. The TUR of the prostate used to be the second most common surgical procedure done in the Medicare age group, cataracts being the first. And now it doesn't even hit the top 10.

DR. REISCHAUER: I'm with you on this so you can hold your fire for my next point.

[Laughter.]

DR. REISCHAUER: Which has to do with the baby boomers retiring. We have to remember that as the baby boomers go on Medicare, they're not coming from the moon. They're coming from the 54-to-64 population. And so as people age they use more services, but the doctor is losing and non-Medicare patient and picking up on Medicare patient.

And so we don't want to just look at the number of people who are going to go on Medicare and think holy God, how are we going to deal with all these people? They are being dealt with right now.

MR. HACKBARTH: Before we go back to the queue, I just want to interject another idea and give people a chance to react to it, as well. Could you put the draft recommendation up?

The second sentence here repeats a previous MedPAC recommendation about providing on a confidential basis physicians with information drawn from the episode grouper.

MR. RICHARDSON: The only distinction being the previous recommendation was directed at the Secretary and this one is Congress.

MR. HACKBARTH: Yes.

I want to raise another idea for consideration on this. Arnie and John, several times in the past, have argued in favor of Medicare making all of its Part B data available for analysis by private payers and others with an eye towards assuring that when evaluation is done of physicians -- and evaluation is being done -- that it's done

with a complete database, as opposed to people working with small fragments based on the number of patients that they may have.

In some ways, this is in the same spirit as Bruce's recommendation from yesterday of making more MA data available so we've got more complete information.

As I think people now, there has actually been some activity on the issue of making Part B data available and others -- Arnie or John -- maybe you can provide the details on that. Because as I understand it, people have been requesting the data. The Department has resisted and it's actually now generated a court case where people are trying to compel the Secretary to make the data available.

And I think there's also been some draft legislation on the issue discussed. I don't know if anything has actually been introduced. Arnie?

DR. MILSTEIN: It has been introduced on both sides of the House, originating in the Senate Budget Committee and then the Senate HELP Committee passed it out 10-0 and there's now discussions between HELP and Senate Finance relating to jurisdictional issues.

MR. HACKBARTH: So I raise it because it is

topical and we may want to think about whether we wish to alter what has been our position for the last several years that this information ought to be released to physicians on a confidential basis. It's a different approach. But I wanted to give people an opportunity to react to that, as well.

MR. BERTKO: Glenn, I think that's a great point to bring up. As we've been talking with Elliott Fisher and all of the folks advocating new accountable care organizations, advanced PHOs, even to the medical home concept, the physician managers and other organizers need this kind of data that wouldn't be no longer on a confidential to the individual physician basis, but appropriately protected so that someone could get it and have it available to help manage the new versions of care organizations I think that might emerge.

MR. HACKBARTH: The other development -- and I'll turn to you in just a second, Arnie -- is that in New York recently there was a negotiated agreement. It was initiated by the Attorney General dealing with some of the private plans. And that agreement -- and I'm not conversant with all the details -- but it basically laid out some ground

rules for physician rating evaluation systems and includes some ideas about how data are properly used and physicians, for example, ought to be able to see it and comment on it, correct problems with it.

Arnie, do you want to just describe that a little bit?

DR. MILSTEIN: Sure. I had a chance to work with the Attorney General's office there, and I think the core of the agreement -- which, by the way, has gotten supportive comments both from the AMA, Consumers Union, AARP, and many other organizations. There seems to be a fair amount of support for it.

But the key elements were number one, there ought to be transparency with respect to how any measurements are calculated and derived. Secondly, there ought to be clarity as to what the margins of error are in the calculations. And third, that there ought to be an opportunity for physicians to get the measurements and have a chance to correct any errors that may be contained within them before they are actually used, whether it's for P4P or for tiering or for transparency. That was the core of the agreement and it was generally widely accepted.

In the course of that discussion, it was completely clear that one of the problems was -- pertinent to Glenn's point -- is a lot of the individual insurers don't have enough denominator size for most measures to calculate a stable estimate of physician performance. And one of the points of advocacy by the Attorney General was the importance of widening the claims database that's used for purposes of calculating measures. And with the exception of OB and pediatrics the Medicare database, obviously appropriately anonymized for beneficiary identity, is by far and away the most rapid solution to that problem, which is certainly not limited to New York but that problem is universal across all 51 states.

DR. KANE: I'm just curious, is there a big difference between sharing Part B data and sharing Part D data?

DR. MILSTEIN: Can I make a comment on that? The proposals in Congress and all of this discussion requires essentially A, B, and D data. And that's really what's been the subject of the proposed legislation and the discussions in New York.

MR. HACKBARTH: Okay. I just wanted to get that

the table. Now we'll go back to the list I had before.

DR. WOLTER: Just a few things for the record. I continue to believe we have significant problems with the logic and the content of the geographic adjustments and practice expense and work RVU. I, too, worry about the workforce issues. And the primary care is big. But I'll tell you, general surgery and critical care is big, too. And based on some of the presentations we've had here at the Commission, there does not seem to be much strategic thinking going on about the apportionment of workforce issues. I really worry about that as we see all these physicians retiring.

On the productivity adjustment, I think we'd be extremely ill-advised to recommend applying that this particular year, partly in the practical context of some years where there's been a zero to 1 percent increase already and we have an unresolved 10 percent decrease ahead of us.

Also, my instincts are that productivity improvements are extremely more variably likely in the physician community than they are in the hospital world because if you're hospital-based, if you're a radiologist or

you're a primary care physician, the opportunities and abilities to tackle productivity are going to really be quite different and, in some cases, really dependant on who you work with.

Also, I really believe that the pay-for-performance world on the physician side is a mess. The PQRI thing is very badly designed. It's been a failure by almost any evaluation. And if we're going to move ahead with pay-for-performance, we really need to think differently as far as how that works in the physician world. And as we've said in other meetings, part of what has to be done is we have to find ways to cross silos, to address the high volume, high cost, some of the more compelling issues that are in front of us with regard to cost and quality. And that just isn't happening right now. I'm sort of embarrassed by the whole thing.

There's a fabulous article in the latest New Yorker about improvements in critical care quality and cost. It's an article by Peter Pronovost from Johns Hopkins. It's very easy to read for anyone, but I think really illustrates the opportunities we have, which is the direction we should go rather than what's going on now.

I wish we could recommend strongly that the SGR be eliminated because I think that has become a huge distraction from tackling the most important issues that we really have on our plate, just to reiterate a past thought that I've had.

Clearly, the need we have for medical education, also to reinforce for physicians the importance of being team members, of approaching quality from a system standpoint, the policy needs we have in gainsharing and bundling, as Karen have said, are tactics that could start to drive us in a new direction.

I also agree with Ron's thought on -- you know, there are some societies doing some wonderful things right now. I don't know if we're capitalizing on that enough, whether it be the thoracic surgeons and their STS database, some of the work the American College of Physicians are doing. There's some work going on around us that might be lessons learned in terms of new directions we could take as we look at physician payment and these other incentives.

DR. MILSTEIN: My comments are more of a synthesis of other Commissioners' comments, not just today but over the last several sessions. I don't know, for non-rookie

commissioners, I think many of us have a sense of Groundhog Day. Here we are, it's time to make the recommendation update, and we fundamentally sense that the update is our most powerful tool but it's the wrong tool for achieving what we want to achieve.

I want to first of all reinforce Karen's comment, is that we've got doctors focused on the wrong beacon. Service great growth in physician services ain't the right signal. We ought to be focused on change in total spending influenced by physicians. And I think, based on some private-sector leadership, we have tools which are not perfect, which I think are good enough to start with in terms of adopting a different signal than rate of physician services growth which is -- for reasons we've talked about -- the wrong signal.

My second comment really just invokes the observation Jay made in September, which is stand back, nobody has more leverage on total spending or patient behavior than physicians. It just has to do with medical practice laws and the psychology of being a patient. And so this is -- physician reimbursement is the largest leverage point on total spending and quality. And so this is

important to focus on.

And then third is, I guess invoking Glenn's comment -- I think it was in September or October -- that if you begin to reverse engineer what's needed for the sustainability of the Medicare program and to begin to lift basic things like adherence to evidence-based medicine up into beyond -- what are we at, two-thirds you said? Or 65 percent, currently, in that range. You would need more powerful motivational those than what we've used in the past. There's a long history of using lesser interventions and not getting anywhere near the kind of delta that we need.

And I think the example of -- I think it's not unreasonable to have much higher expectations of the U.S. health care industry. I think it can do so much better. And I think what Nick cited is just a great example.

Basically in the state of Michigan, they virtually eradicated central line infections, which if you would have come to any group of providers and say do that, they would have said it can't be done. But it was a question of attitude and will and, in that case, pure professionalism, which is to be admired.

So where does this lead me in terms of what's my recommendation? I think that this notion of confidential feedback systems makes sense to me for a very short term. We obviously could use a couple of years to work with the specialty societies to come up with somewhat more robust efficiency and quality measures. I wouldn't wait much more than two years for it because there has been, courtesy of NQF, AQA and the progressive societies, a fair amount of prior work done.

So I would say confidential feedback with our less perfect measures for no more than two years and then let's move forward with more robust, more robust relationships between performance and reward including public reporting.

So I would like to think about, if you think about what our tools are it's basically P4P, reimbursement reform, or public reporting, the latter being a way of motivating more professionalism. None of those tools are available to us and they're darn hard to move forward.

So should we, along our discussion yesterday, consider some kind of a more performance sensitive approach to the update as an additional horse in the race and be able to adapt our update recommendation to such a notion of a

performance update that begins to be sensitive to individual provider performance, both differences and improvement.

And I think what the GAO, in their spring report, did on efficiency is one way to go. They basically said let's not disturb all physicians. Let's identify those that appear to be a far outliers and begin to engage them. Then we can move up the chain. So that's idea number one.

MR. HACKBARTH: So, for example, you'd do episode grouper analysis and identify some upper rank of physicians and say they get a lower update than other physicians?

DR. MILSTEIN: And I'd would want to blend that with specialty society recommended quality measures. And also, we'd want to find ways, and I think there are ways, for adjusting for some of the weaknesses in episode groupers, especially for CHF and CAD, which Niall and company -- but that's the general direction.

Secondly, we've discussed many times before, is with respect to the underlying payment system -- I realize this is a bit off track for update -- but I think there's a lot of support within the Commission along the lines of what Karen was suggesting, moving from resource-based RBS to value-based RBS. What's the evidence that the service

actually lifts health status? That could be graded.

Yes, we'd be challenged until such time as our comparative effectiveness center is up and going, but we could start with what we have. I think there would be a lot of support for establishing a care coordination fee, not necessarily limited to primary care physicians and letting patients elect and then beginning to pay for care coordination, which we need.

The third and final idea is this idea of we put the concepts on reports but we don't actually recommend specific implementation, is better coordination between Medicare and private sector in how we measure and how we signal to doctors as well as other providers what we value. And I think the first step along that road -- which is a nontrivial road to walk -- would at least be for us to support what the Business Roundtable, what organized labor and what Consumers Union and the New York Times and many other parties have supported, which is enabling provider performance reports to be generated using the Medicare database, beneficiary anonymized, so that the signals coming from the private sector to doctors and hospitals with regard to what good performance is can be better synced with

Medicare.

DR. DEAN: Some of this may be hopefully not too repetitive.

First of all, thank you for the presentation. And I wanted to highlight the first comment you made about the possible changes looking at misvalued services, which is sort of what we've been talking about. But it's really evident in the stuff that I do. I can sew up a simple laceration and get paid three or four times as much as if I spend 30 minutes with an elderly person with four or five diagnoses, trying to figure what they are actually doing and what they're actually taking, and trying to get them on a more legitimate regimen.

And in terms of the effort involved, the problem is that was you've prepared to laceration it's very easy to document that that happened. The other exercise is very difficult because it's hard to tell what kind of report you're going to get from the patient afterwards, whether we actually did anything.

And yet in terms of getting to the value, at least I would hope that the second service has significantly more value than the first. But it's really tough. And I'm sure

what Karen said in terms of trying to come up with a way to document that from a CPT point of view or whatever is very hard. But I think there's just no question that we need to move in that direction because obviously those are the kinds of activities that are not getting done adequately in the current structure.

Secondly, just a quick comment on the workforce issue. I happen to have a son who's midway through medical school right now so I have a little perspective on that and would just emphasize everything everybody has said. His colleagues are looking very much at very narrow subspecialties. This is even at the University of South Dakota, which is not a subspecialty oriented organization and has traditionally been an organization that produced high numbers of primary care providers. And their numbers have gone heavily in the other direction.

Turning that around is a long-term process. And so it's going to be a big challenge.

Finally, I certainly agree with what Karen said about simplifying the process. Just as an interesting point, last night on the Commonwealth Fund website there was a paper showed up that was very challenging. It was How Do

We Produce Value -- I forget the exact title. But it was written by for docs. And they really called into question the effectiveness of our current mechanisms, pay-for-performance, public reporting.

Their argument was that any procedure that sort of isolates individual physicians really works against the direction they we're trying to move. In other words, if we're really trying to build a system of collaboration and coordination and so forth, if we isolate individual physicians and try to -- first of all, evaluating their performance individually is difficult to do when there are so many people involved in the care of any one patient.

And secondly, their argument was -- as I understood it, and I have to admit I just read it very quickly and only read the summary -- that if you do that you actually aggravate the whole silo issue and you may actually provide incentives for people to push certain procedures to somebody else so it doesn't get put on their account and various other things.

So even though I believe that individual reporting of resource use makes some sense, like I said this was a very interesting perspective and I think one that deserves

some attention.

DR. MILSTEIN: Briefly on this point, I completely agree with that. Here's the paradox related to this, is that performance improvement, and indeed even current patient care, is a team sport. There's no one doctor.

But energy to improve completely depends on identifiability of individuals who have the most power over the course of a patient's care. You have to create motivation at the individual level and the direction you want to channel that motivation is toward team solutions.

MR. HACKBARTH: On your first point about the laceration versus spending a lot of time, I've had several physicians say to me recently MedPAC could do a great service if it would just publish all of the RVUs converted to the implied hourly wage, put it in plain English that people can understand, and let people see the values that we're attaching to the time spent for different things.

How much work would it be to do that? I know Kevin did some of it for a few things, but I made the whole damn list, just say here's the implied hourly wage?

DR. HAYES: To do what I did for October, I started with each individual code and then just put them in

the different service categories. So I've kind of already done it.

MR. HACKBARTH: So you have it all? You just showed us some but you have it for all already?

DR. HAYES: Yes.

MR. HACKBARTH: Let's think about what to do with that.

DR. MILLER: So Kevin is saying is it's really hard.

DR. HAYES: It was at the time.

[Laughter.]

MR. HACKBARTH: We need to cruise towards our conclusion here. I have Nancy-Ann and then Jennie wanted to make a brief comment, as well.

MS. DePARLE: This is a little bit, I guess taking the pin out of the grenade, but Nick started it. I agree with everything Arnie said about how we could do a better job of collecting and reporting this information for two years on a confidential basis and then going out more publicly with it.

To me, I'm looking at John Richardson here, and for 15 years we've been working around this SGR, and he and

I work on it when we were both at OMB. I am still struggling with what we have achieved. The best case I've heard is from John Bertko maybe a year ago or when we were debating this last year about the trajectory of spending has been, we think, slightly lower because of the SGR than it would have been.

But if you look at everything else, and go back to Arnie's point about the leverage point that the physicians have, why have some of those other things gone up the way they have? Imaging, some of the things we've talked about here.

So I find it very hard to make the case for this, for the SGR. So I'm with Nick. I say I would support saying let's do away with it. It's become an enormous distraction from paying what we should be paying for.

Glenn, you made the point a minute ago about plain English. Part of the problem is no one understands this. I don't think the average physician could be expected to understand it. So I don't think we're conveying what Medicare wants to be paying for or buying through this system. If it's constraining growth we're concerned about and inappropriate spending, there has to be a better way of

doing it than this.

MR. HACKBARTH: Just a quick reaction on this. We spend a lot of time on the SGR. Was it last year that we finished it. It was for March of last year, this spring, that we finished. How could I forgot?

[Laughter.]

MR. HACKBARTH: What I noticed during those lengthy discussions is that as the time has passed, and perhaps the composition of the Commission has changed, the view of the SGR has shifted a little bit. I can give you a great 10 minute speech on the flaws inherent in the SGR mechanism, why it won't work to control volume, why it more likely will increase volume, why it's inequitable, et cetera.

However, when we talked about the SGR report, we had a significant number of commissioners who said all of that is true and we still need a club -- I think was the expression used -- to force action. So whatever the intellectual merit of the anti-SGR argument, and it's great, in this current system which is utterly out-of-control there were a significant number of physicians that said this is better than nothing at all.

We struggled to try to bridge that disagreement. It was a critical reason why we ended up going to Congress saying here are two alternative paths, one that includes continuation and one repeal, which I got a beating over, that we couldn't agree. I just don't see it's going to be productive for us to go back and try and do it all over again. So I know all of the arguments against the SGR. I think there are strong arguments. But there is a disagreement about repeal at this point.

Did that cover what you wanted to say?

MR. BERTKO: Yes.

MR. HACKBARTH: Did you have any other point, Nancy-Ann?

MS. DePARLE: A no.

MR. HACKBARTH: Jennie.

MS. HANSEN: I'm definitely there for the plain English component of it. I think that when we think of 43 million beneficiaries, the ability to take some of these topics and have the salience of that. I'm struck by a short informal conversation I just had with Bill that sometimes I feel like we're trying to do air spray over stuff that's fermenting in such a big way that we're just doing a bit of

a cover.

I actually had two requests. One of them relates to points that were made by Karen and Nick and Tom relative to this whole aspect of workforce in primary care. When we keep talking about primary care and all the inherent issues related to the funding and all that, it feels like we're trying to squeeze blood out of a turnip and have people go into primary care. It's like an entreaty that's not happening.

And yet at the other hand people are going to need care and we've talked about complementary providers, nurse practitioners, other people. I wonder, in the course of looking at this recommendation, one of the things was to maintain current supply. Well, current supply is not great even though the numbers, I know, in terms of access look okay. But can we begin to project ahead and perhaps have some text related to what is this potential other complementary workforce that can provide that? It's already appearing in the marketplace. The convenient care centers are cropping up. The market will speak to that.

So if we could also basically array some information as to who might be there in the wings. If

physicians don't want to do this as primary care, not that many don't, but the incentives aren't there, care is going to be needed, people are going to get care, who are they going to get care from? So let's begin to prepare for that.

So I'd love to have some text on who are there? What are they doing? Who's the backup team, so to speak, on the bench ready to go?

Secondly, the other request I have, the other point on the recommendation is the beneficiary impact of cost sharing. We've talked about this with the Part B premiums as well as the cost of -- the copayments that people have to make. I really want to tie that back to yesterday's presentation by Joan and Hannah relative to the beneficiaries' profile of income and health care spending.

And as this occurs, again plain English. What does this mean for regular people, to have basically $1,000 of income on average -- apparently 90 percent of Medicare beneficiaries are relying on Social Security and the average Social Security check per month is about $1,000. They already are paying three times their income relative to the under-65 population for their health care costs.

Here we're going to ask them to pay that much more

of their $1,000. I'd love to be able to show what the real impact is, also in plain English, on behalf of regular beneficiaries.

So work that's already been done, I'd like to tie this actually to this chapter as to what this really means as costs occur, when you have the copayments that come with the A, B and , for people. Thank you.

MR. HACKBARTH: Just one last thing that I want to call to your attention so people can think about it for January and our final recommendations. Nick mentioned his reservations about where we are on P4P for physicians and this isn't just an ineffective path but a destructive path I think was the essence of what Nick said.

DR. WOLTER: I didn't say that but...

MR. HACKBARTH: This is not a new point. Nick has made this argument before and I think has had an effect certainly on my view and I think on the view of many commissioners about where we stand with P4P for physicians.

What we've tried to do in the draft recommendations is sort of provide an updated notion of where we actually stand on P4P. It's sort of beneath the surface and I want to bring it to the surface.

You'll recall in the hospital draft recommendation it said full market basket update concurrent with implementation of a P4P program. My own view, and I think most of you were here but I'll want to check, is that hospital P4P is relatively easier to do and readier to go than physician pay-for-performance. And so we said last year let's get on with it, let's do it. So we've crafted the draft recommendation to reflect that and actually we approved that last year.

The SNF discussion, you'll recall from yesterday, there was a new P4P recommendation. Previously we had not recommended P4P for SNFs because we didn't think the measures were adequate. There are now some measures that we think are stronger, so we've offered a draft recommendation saying we endorse pay-for-performance for SNFs. And I want you to think carefully about that.

On Medicare Advantage, which we discussed yesterday, we have a text box which reviews our past recommendations which include a P4P for Medicare Advantage plans. My belief, and I think it's been the Commission's, is that that is again a relatively easy area to do pay-for-performance and it's ready to go. And then, in just a few

minutes we'll be talking about ESRD, where you'll see the draft recommendation is crafted to include a reiteration of our support for pay-for-performance in this area.

We did not do it in home health, which is an area where some commissioners have expressed reservations about P4P. Bill, in particular, has made that argument. I guess we've never recommended for long-term care hospitals and IRFs.

So there's a pattern here that I want you to see where the draft recommendations include P4P in areas where I think we have agreement. And so think about that for the next time. When I talk to you individually between the meetings, that's what I'm going to try to be getting a sense of, where do we stand on P4P in the different areas.

DR. WOLTER: Just a quick comment, and hopefully this will be for future discussions here at the Commission.

I wish we had patient pay-for-performance in the sense that in the six IOM aims obviously patient centered is a key element. We should be focusing on congestive heart failure, ventilator-acquired pneumonias, central line infections. We should synthesize the points of view expressed by Tom and Arnie about the role of individual and

team performance. And our payment silos don't allow that. And so it's complicated, but we need to think differently than we have been.

MR. HACKBARTH: Last brief comment.

DR. DEAN: I just wanted to add one more thing on the list to the arguments against the SGR, and that is what Nick said, that is a huge distraction in the physician community right now, and the need -- as Arnie said -- to really get physicians involved in more logical and productive thinking about what we can do to improve the system. They're so focused on and so angry, many of them, about this issue that they're not even interested in that. And so I think that's an argument for removing it.

And just to follow up on Jennie's point about the mid-level practitioners, I've worked with PAs and nurse practitioners and midwives for 30 years. And actually, I couldn't be where I am if it wasn't for that.

At the same time, I am absolutely firmly convinced that it only works when you do have a team and you have close coordination. I won't get into a long discussion, but like I said, I am a total firm advocate of their role and they have done tremendous things in allowing me to be where

I'm at. But I think it needs to be a team effort.

MS. HANSEN: And I didn't mean to imply that would be a takeover. I, too, worked 25 years with physicians and nurse practitioners together. But it's the ability to have a greater volume of people with greater efficiency.

DR. DEAN: Absolutely.

MR. HACKBARTH: Okay, thank you all. Good job.

Next up is dialysis

MS. RAY: Good morning.

There are more than 350,000 dialysis patients in the U.S. Most of these patients are covered by Medicare. Thus, how Medicare pays for outpatient analysis services is relevant to their care.

My presentation on outpatient dialysis is composed of two parts. First, I will provide you with information to help support your assessment of the adequacy of Medicare's payments for dialysis services. Second, I will present a draft recommendation for you to consider about updating the composite rate for calendar year 2009.

Here are the six payment adequacy factors that you've already seen. Much of the findings from this year's analysis is similar to last year's adequacy analysis. It is

a little bit like Groundhog's Day. But I will highlight several differences between last year's analysis and this year's analysis.

Access for most beneficiaries appears to be good. There was a net increase of about 200 facilities between 2006 and 2007. The number of dialysis stations is keeping pace with the growth of the patient population. Between 1997 and 2007 stations have increased by about 6 percent per year, while during the 10 past years the growth of patients has increased by about 5 percent per year.

During this period, facilities are getting bigger. That is there are more hemodialysis stations, on average, in 2007 than there were in 1997 in a dialysis facility.

There is little change in the mix of patients providers treat. For example, the demographics and clinical characteristics of patients treated by freestanding facilities did not change between 2005 and 2006.

We looked at the characteristics of patients treated at facilities that closed versus facilities that stayed in business in 2005 and 2006 to see if particular patient groups are disproportionately being affected by closures. Some of what we found is intuitive. Facilities

that close are more likely to be smaller and less profitable than those that remained in business. Like last year's analysis, we still see that dual eligibles and African-Americans are over represented in facilities that closed compared to newly opened facilities.

Importantly, however, the proportion of duals and African-Americans treated at facilities that remained in business in both years closely matches the share of these groups among all dialysis patients.

In conclusion, we will keep monitoring patient characteristics for different provider types but again, based on all of the evidence, access appears to be good.

There are about 4,800 dialysis facilities in the U.S. Most providers are freestanding and for profit. About 60 percent of all facilities are affiliated with two national for-profit chains, Fresenius and DaVita. And 70 percent of all freestanding facilities are operated by these two chains.

This slide shows that the two largest chains operate in most states. Together, these two chains operate in about 47 states. The red dot are called LDOs, large dialysis organizations. That's the two national chains.

The green dot is other freestanding facilities. And the yellow dot is hospital-based facilities.

We looked at a number of pieces of information about the changes in the volume of services in payments for dialysis services. First, we see that the growth in the number of dialysis treatments has kept pace with the growth in the patient population. However, spending patterns have changed. Expenditures for composite rate services have increased while expenditures for drugs have decreased between 2004 and 2006. Why did this happen? Because of changes mandated by the MMA.

The MMA changes decreased drug payments for separately billable drugs. As intended by law, CMS paid dialysis providers the average acquisition payment in 2005, which lowered the drug payment rate compared to 2004. CMS paid dialysis providers 106 percent of the average sales price in 2006 which again dropped the dialysis drug payment rate between 2005 and 2006.

At the same time, the MMA increased payment for composite rate services by 8.7 percent in 2005 and 14.5 percent in 2006 through an add-on payment. And just to remind you, the add-on payment is financed by shifting part

of a drug profits to the composite rate.

This figure shows the change in spending patterns. What you see here is the trade-off in payments for drugs and composite rate services. Again, the MMA moved some drug payments to the composite rate.

Now between 2004 and 2006, total spending increased but at a slower rate, at about 6 percent per year. By contrast, between 1996 and 2004, total spending grew by about 10 percent per year. This slow down is a function of the change in drug spending after 2004. Between 2004 and 2006, drug payments fell by 5 percent per year. By contrast, between 1996 and 2004, drug payments grew about 15 percent per year.

The drop in drug spending is driven by the drop in Medicare's payment rate for dialysis drugs for epo and most other dialysis drugs. The question is what has happened to the volume of drugs? And were patient outcomes affected?

Holding price constants, we find that the volume of epo -- and epo accounts for about 75 percent of all dialysis drug spending, erythropoietin -- and most other leading dialysis drugs has increased.

Holding price constant, erythropoietin volume

increased by about 2 percent per year between 2004 and 2006 and the aggregate volume of the other leading dialysis drugs increased by 9 percent per year between 2004 and 2006. This is basically what we found last year with one exception. The volume of one drug has declined, and there is no injectable substitute. Patients may be getting its oral counterpart. We cannot confirm this because we do not have Part D data yet. And of course, you made a recommendation to this issue yesterday.

Moving on to changes in volume, we also looked at changes in the dose of erythropoietin per treatment and there we see that it did increase by a small amount between 2004 and 2006.

As we will see later, quality is measured by the proportion of patients receiving adequate dialysis and with their anemia under control has not been affected -- has remained relatively unchanged since 2004.

So I think there's two stories to keep in mind when considering the growth in dialysis drugs. First, clinical guidelines have recommended their use. At the same time, Medicare's payment policy has promoted their use. Medicare pays according to the number of units given and

drugs are profitable, even after the MMA's changes. The OIG has shown that dialysis drugs have remained profitable for most dialysis providers, at least through the third quarter of 2006.

Several researchers have shown that epo dosing practices vary across providers. And issue then is whether the payment method provides an incentive for the overuse of epo. High use of epo is associated with negative side effects for some patients.

In 2007, the FDA reviewed the safety of epo and issued new warnings for clinicians to carefully prescribe them. This is one reason why we recommended a broader payment bundle to pay for dialysis services that includes dialysis drugs, including epo.

Moving on to dialysis quality, it is improving for some measures: the proportion of patients receiving adequate dialysis and patients with their anemia under control. Use of fistulas is increasing. One quality measure, nutritional status, has shown little change over time. Rates of hospitalization are high and relatively unchanged over the past decade.

At the end of your briefing paper is a section on

the different options for improving patients' nutritional status and vascular access care. Recall we discussed these options at the November meeting. I'm not going to go into them right now but we'll be happy to take any questions you might have.

Regarding access to capital, indicators suggest it is adequate. There is an increase in the number of facilities. Providers have access to private capital to fund acquisitions. Analysts are positive about the two largest publicly traded chains.

So let's move to our analysis of Medicare's payments and costs, and specifically our audit correction. Our margin analysis is based on costs being Medicare allowable. That is why we have considered how CMS's audit efforts affect the level of costs. The BBA mandated that CMS audit facilities' cost reports every three years. For last year's report, we used 2001 audited cost reports. This year we analyzed 2004 and 2005 audited cost reports. For the same facilities, we calculated the cost per treatment before and after CMS audited their reports.

We find that the difference between reported and allowed costs has narrowed between 2001 and 2005. In other

words, the difference in 2005 between reported and allowed costs is smaller than it was in 2001. Consequently, we did not correct providers' costs in this year's analysis. But we will update this analysis next year and reevaluate whether to correct costs based on CMS's auditing efforts.

Here is the Medicare margin for 2000, 2005 and 2006. It was 5.9 percent in 2006 and we project it will be 2.6 percent in 2008. There are four points I would like you to keep in mind. One, drugs were still profitable under Medicare's payment policy in 2006 and that 106 percent of average sales price. The OIG has confirmed this in a survey they conducted of providers' costs.

Two, part of the drug profit moved to the composite rate in 2005 and 2006. So even though drug spending fell, the composite rate payment amount was increased.

Three, providers have received updates to the composite rate and the add-on payment in 2005 and 2006 and 2007. Providers received a 1.6 percent update in 2006 and another update to the composite rate of 1.6 percent beginning in April of 2007.

Also, the add-on payment to the composite rate was

updated by 1.4 percent in 2006 and 0.5 percent in 2007 and in 2008.

The fourth point I'd like you to keep in mind is that the drug cost per treatment has remained relatively flat between 2005 and 2006.

Back to just looking at 2006 payment and cost data. You can see here that the Medicare margin varies by provider type. It was larger for the largest two chains than for everybody else. This reflects differences in drug's profitability between these provider groups and lower costs per treatment. Chains get better pricing for drugs than non-chains and there's also efficiencies of scale which shows up in lower composite rate costs per treatment for chains versus everybody else.

The second part of our update process is to consider cost changes in the payment year we are making a recommendation for, 2009. CMS's ESRD market basket projects providers' cost will increase by 2.5 percent in 2009. As is the case with other provider groups, we considered the Commission's policy goal to create incentives for efficiency.

So I would like to start your discussion with last

year's recommendation. It is that the Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less the adjustment for productivity growth for calendar year 2009, concurrent with implementation of a quality incentive program.

Recall that in our March 2004 report, the Commission made a recommendation for a quality incentive program for physicians and facilities who treat dialysis patients. And again to remind you, the productivity growth is estimated at 1.5 percent.

There is no provision in current law for an update, so this would increase Federal spending. It would maintain beneficiary access to care but increase beneficiary copayment and deductible. So the net increase with the 2.5 percent market basket and the 1.5 percent productivity growth would be a net to a 1 percent increase in the composite rate.

I look forward to your discussion about this information.

MR. HACKBARTH: Question, comments?

MR. EBELER: I have one question and one comment. The question is do we have data on the distribution of

margins among facilities? Are there a cluster of very high margin, medium margin, low margin, the way we've seen with other facilities?

MS. RAY: We could break that out for you for the next meeting. What we've done here is at least provided for the two largest chains and everybody else, all other freestanding. But we can also look at margins, as in the other sectors, for the 25th percentile and the 75th percentile.

MR. EBELER: I think of this issue of what an efficiently and economically operated facility, and it would be useful to have those data.

On the recommendation, I would just reflect that we have a couple of places where we talk about a productivity offset to the market basket update. It strikes me that this is a place where it's appropriate. I argued yesterday that we should consider doing that in the hospital field, as well.

I think Nick made a good point earlier that it's the type of thing one may expect a little more easily in institutional providers than one can expect in a physician practice. It's an interesting way to calibrate that policy.

DR. REISCHAUER: We don't have margins by facility for the ones that are in chains, do we?

DR. MILLER: Nancy, you do?

MS. RAY: Yes, I do.

DR. REISCHAUER: Really? I would think there would be a huge transfer pricing problem here, how you allocate some certain overhead costs across the units of a chain.

MS. RAY: Medicare makes available cost reports for each facility and on that cost report you can identify the facility, sure.

DR. MILLER: But there is something of an issue of home office allocation and those type. That's the point he's making.

MS. RAY: Yes.

DR. MILLER: Does the audit deal with any of that? Or is the audit more on operation types of things?

MS. RAY: I would have to look into that.

MS. DePARLE: Thanks, Nancy. And though you did not repeat the recommendations of the discussion that we had last time about the nutritional status, you incorporated it by reference. Again, thanks for your work on that.

You and I have had discussions about this audit correction. And I'm interested in your finding a smaller difference between the reported and allowed costs for the facilities in 2004 and 2005 than you had in the past. As I recall, the reason for the audit correction was because there was that discrepancy. I had taken exception with why do we do an audit correction for this sector and not for other sectors, and that was the reason.

What do you think is going on here? Just better reporting? More consolidation in the industry? Do you have any idea?

DR. MILLER: Nancy, do you want me to answer this? Nancy holds these feelings fairly strongly, so maybe I should -- I'll start off.

MS. DePARLE: I can take it. Is it something she's afraid to tell me?

[Laughter.]

DR. MILLER: It's Nancy that I'm worried about. I'm not worried about you.

[Laughter.]

DR. MILLER: The industry has come in and talked to us several times about what they're trying to

systematically do to improve how this audit process has gone. So they have definitely over the last few years have said that they've noticed -- not noticed. They've realized this problem and have tried to take steps within their own reporting to narrow some of it.

I would say two things, and Nancy this is all giving you time to think through things. That may be having an effect. And then data can be fairly squirrelly.

And I think what Nancy is thinking is she's going to continue to look at this. And if this variability comes back, she may be back to talk about the audit correction again.

MS. DePARLE: So it may just be an aberration? It may just be that one year it was closer or a couple of years it was closer?

DR. MILLER: Go ahead, Nancy.

MS. RAY: Right now the difference narrowed was small in 2004 and even smaller in 2005 -- I'm sorry, I have the dates wrong. It was small in 2005 and even smaller in 2006. We'll see what happens the next year's audit.

There is some variation from year to year in data sometimes. I'd like to see what happens with this trend.

MS. BEHROOZI: Nancy, can you go back to your slide three for a minute please, just for a clarification. I wasn't sure I heard correctly what you said.

You said that dual eligible and African-Americans were overrepresented in facilities that closed in 2005. Did you say you saw that trend continuing in 2006?

MS. RAY: Last year we compared facilities that opened and closed and we did it for the 2004 to 2005 time period.

MS. BEHROOZI: So we haven't revisited that?

MS. RAY: We did. This year we did it for 2005 to 2006, and again we see the same finding, that African-Americans and duals are overly represented.

However, when you looked at the facilities that stayed open, the share of patients that are African-American and duals equals their proportion that they are among all patients.

MS. BEHROOZI: Because in the paper it made it look like the demographics didn't change in the facilities that stayed open, which makes me wonder where the people are going from the facilities that are closing.

MS. RAY: Right, it appears that they are going to

facilities that remained in business in both years, yes.

MS. BEHROOZI: So the demographics of the one that remained open changed enough to accommodate the greater share?

MS. RAY: Yes.

MS. BEHROOZI: That's what I didn't understand.

MS. RAY: And to keep in mind that the number of facilities that closed is very small. So you're not going to see that big of an impact in the characteristics of facilities that stayed open.

MS. BEHROOZI: Okay, thanks.

DR. KANE: I'm just trying to get some sense of a principle for how we make these recommendations. I know this is fruitless because I've tried it before, but to make sure I understand.

In the past they looked like they had roughly a 5 percent margin with variability by the chains quite a bit higher. And then the non-chain quite a bit lower but still profitable. And we're projecting roughly that to drop in half in 2008. And we still make the same recommendation that we have in every single year in the past, which is the usual update minus the productivity.

So what makes us change from that path?

DR. REISCHAUER: We wait for a new commissioner like Jack to come along.

MR. HACKBARTH: Obviously, this relates back to the hospital discussion yesterday. The analysis that we do looks at a bunch of different factors, of which margins are one. But since they're numbers and it's the bottom line, there's a natural tendency I think for people to say well, this is really about the margin and there ought to be some formula that links the margin to what the recommended update is.

In fact, though, in the seven years, eight years that I've been on the Commission, we've always resisted targeting a margin and saying there is a formulaic link between the update and the existing margin. My own view, and I know this isn't shared by anybody by any stretch -- but my own view is that margins are less and less important to what I think about what the update should be for the reasons I said yesterday. I don't think we can afford to follow costs and just say well, we're going to increase our payment rates to achieve a target margin. I think we need to be about changing cost curves, and that means applying

pressure, downward pressure, in a consistent way.

Now in some instances we may, when the margin gets to minus five for hospitals, we may say okay, we're going to adjust a little bit here. We're going to drop the productivity but link it to pay-for-performance. It's a judgment call.

But I don't think that there is or should be a formulaic link between updates and margins. I think that would be a profound error.

DR. KANE: Could I just back up one more step then? Why don't we recommend a zero update? Sometimes we do. They look like they're doing fine and there's a decent margin, there's plenty of access.

MR. HACKBARTH: We can. It's a judgment call. So make the case. Jack made the case yesterday for a lower number for IRFs, I think it was.

MR. EBELER: IRFs and hospitals.

MR. HACKBARTH: Make the case. It is a judgment call. That's the important point.

DR. KANE: Okay, I'll think about it.

DR. STUART: I think part of the issue depends upon whether this is proprietary or a not-for-profit sector.

Clearly, if we're dealing with for-profit entities, they're only going to say in business if they have a margin, at least over time. That's not to say that you base it on the margin. What it's to say is that you look at what the response is to the past recommendations and the actions of Congress.

So my question is over the pass three or four -- well, maybe just the past two years -- what is the relationship between the projected margin, which I think does not include behavioral response if I'm not mistaken, but I'll make that a question -- and the actual margin that has been achieved?

Because I think the point you're making, Glenn, is that you have a target. And with no behavioral change that target might -- the arithmetic might come out to a zero margin or a negative margin. But you're actually trying to push behavior. So the question is what have you done in the past? And what is the impact of that?

And then I think we can get back to Nancy's question, what would you expect to be the behavioral change if you had a zero percent update in this particular case?

DR. KANE: Part of what used to sway us, I think,

for the post-acutes was you used to see what it was before the PPS system and where costs and payments were very close. And then you see this sudden shoot up of payments relative to costs. It was obvious -- but we don't seem to have that kind of a chart here.

So that would be maybe helpful, to see what the last five years of payment to costs have been, even though I know there's been all of these complicated changes with respect to the way they pay for drugs. But maybe we can do an adjustment for that and just see what the trend has been in terms of payment relative to costs, as well as the growth rate.

DR. MILLER: Though we don't have those separately broken out, you do have that, which is the summary.

DR. STUART: My point wasn't the margin itself. It was the projected margin that MedPAC had for each of these years relative to what the actual margin was after we had the information.

MR. HACKBARTH: Let me just say see if I can play it back and get it right. So your question, Bruce, is is there evidence that if you constrain the updates, for example, that people respond to that by lowering their cost

increases and they're able to deal with that pressure?

I think the short answer -- and staff can correct me if I'm wrong -- there are cases where that seems to be true. For example, home health, it's had sort of an up-and-down in terms of the update. But they seem to be able to reduce their cost to stay with an almost any update and keep very high margins.

Hospitals, again the updates have tended to be relatively high recently by statute. But the link between the payment rates and cost is less strong there. And I think the confounding factor is what's happening on the private side.

DR. STUART: I don't think it's a confounding factor. I think that if you've got a sector that is driven by a not-for-profit providers, then why are they making profit? The reason they make profit is so that they can make more services available.

And so it's almost axiomatic that if you give them more money, then they're going to spend more.

MR. HACKBARTH: This is true.

DR. STUART: That's not axiomatic in the private for-profit sector.

MR. HACKBARTH: I agree with that. And even if Medicare does not give them more, they're going to spend more so long as the money is flowing in from the private side.

DR. STUART: Right. And actually that influences the behavior of for-profit hospitals, too. So the question is this is a market that I think is dominated by for-profits and so I would expect different behavior at the market level than I would in the hospital industry.

DR. KANE: Apropos the same issue of thinking about do we want to have an update, if the efficient provider are these two chains, do we want to call that the level that we're looking at? With hospitals we say we're trying to pay at the rate of the efficient hospital. And yet if we did that with these guys, you need to be in a big chain to be efficient? Are we prepared to say we might be putting the little guys out of business? Or do we want to adjust the update?

DR. STUART: Well, you know, you don't make a decision on cost alone. You make it on cost and quality. So one of the questions would be the extent to which these quality measures, in fact, differ systematically between the

large chains and the small chains and the stand-alones.

DR. KANE: Do we want that picture in the industry? Or do we want to say the efficient unit is a chain and we want to have everybody be in an efficient unit? Is there a benefit to having small providers in the marketplace? Or do we want to have larger, much more efficient chains?

MR. HACKBARTH: My own view is that your definition of efficiency needs to include cost and quality. Let's stipulate that for a second.

Once you've got it, then we ought to be setting our updates at the level of efficient providers. If that means that smaller units can't cut it, I think they ought to go away.

DR. KANE: Is there a quality differential by size then? That would be helpful to know in thinking about this.

DR. REISCHAUER: But you look at the map and there is another issue, which is access in rural areas here. And you want to look at the for-profit/not-for-profit split there. It could argue for special rural payments.

MR. HACKBARTH: Exactly. What you would not want

to do is pay everybody everywhere more money above the efficient provider level to deal with specific targeted access problems. If you want to subsidize access in some areas, you do that directly. But don't just pay everybody more. That's crazy.

DR. KANE: Jack and I have just found out how to make these discussions less than a Groundhog Day, so thank you. That's to propose a cut.

DR. SCANLON: I was going to add something to what Bruce said. I agree with him completely about nonprofits in terms of that there is, in some respects, an obligation to spend the money on something. And to the extent that they expand the services they provide, that can be a very good thing.

There's the other issue which is to what extent do some of the expenses that nonprofits have represent hidden dividends to the management of those nonprofits in terms of the salaries that are in excess of what they should have been? That's potential reality.

On the for-profit side, I don't think we should think that because they're for-profit and they file a cost report, that the cost reports represent the economic cost of

providing a service. When we had cost-based reimbursement, we had just unbelievable examples in terms of how costs that are reported by the rules were not necessarily economic costs in terms of that they were absolutely necessary, particularly when we got into the capital side of things and how things were recorded in terms of the buildings, the ownership of the buildings, the rental of the buildings. And then, as you move into the operation side, there's the whole issue of related party transactions.

So the cost that we're seeing here, they're markers for us but they're not -- we shouldn't put too much faith in them.

DR. MILLER: That's something that I would say, and to Glenn's point about the margin. It's an indicator. It's a number and people tend to gravitate to it. But it can be very noisy, depending on what's going on with the cost report and what happens to be going on with the industry at any point in time.

And to your point in terms of the forecast and how it tracks, what's hard to do in that instance is if somebody takes legislative or administrative action, it's not a secular trend process. So if the CHAMP Act provisions in

long-term care hospital go into affect, the estimate that we've put in front of you we know will be way wrong.

DR. STUART: And I appreciate that. But there was a comment yesterday to the extent that costing out these policy changes is relatively easy compared to costing out behavioral responses to changes. And so I'm thinking well, if you guys can do that, then maybe you can decompose the change in terms of what you think is associated with the change in policy and what you think is associated with a change in the behavioral response to that policy.

DR. MILLER: And with all respect, I think that some of the payment policy changes are easy to model. Some of them, and particularly the couple in play right now on behavioral response to the 75 percent rule, actually confuses both of those comments and the ability to parse it is really hard.

This is not to reject what you're saying. I just want people to understand how -- even though it's a number and everybody tracks to it -- the precision of it can be influenced in a lot of ways.

DR. STUART: I think it's the philosophic base that's the most important here, is that you really do expect

that providers are going to respond to these if you don't give them an update as opposed to if you do give them an update.

DR. BORMAN: I'm not competent to comment on this nice discussion about margins and numbers, but as you pointed out, Glenn, we're linking our notion of moving forward with quality measures and programs with the various update recommendations. I would like to link this to something that Nick brought up in that I do firmly believe that the patient P4P concept is a very important one, to some degree.

And if we do have the ability to go down this road a little bit, the patient population in this particular part of the program would seem to be the ideal starting point in that there's a homogeneous disease, these are people that have frequent mandatory reasons to seek medical care, their compliance, adherence, whatever you want to call it, with what they need to do, what they're directed to, does make a huge influence on their progress. And they're getting a therapy that is very costly and that we've made a societal decision to support, but that clearly in a time of constrained resources, we have to know that we're getting

maximally out of it.

So I would like to maybe set in the background -- not that it has a place in the discussion of the payment update about this -- but a notion that as we look to where does the beneficiary, where does the patient fit into this, just as Jennie makes great points about considering the cost to the beneficiary and the impact on their income, I think the flip side of it is also looking at the beneficiary responsibility. This is the ideal patient population, I would think on first blush, to do that.

MR. HACKBARTH: Just make it a little bit more concrete for me, Karen. Or maybe, Nick, you can help with this. What would patient P4P mean in the context of dialysis? What does that mean to you? How do you adjust payments? Based on what factors, what variables? Is it just satisfaction? Some of the P4P metrics already are patient satisfaction. It sounds like you want something more than that.

DR. BORMAN: I'm looking at for -- these people are getting regular measurements of their status. And so when a patient's status deteriorates for no other explanation than patient nonadherence, then I think we have

to ask the question does that patient get the same range of services subsidized?

And I recognize that's a very politically unpopular notion. But I think when we're critically looking at how we invest our dollars in a very expensive therapy, do they have a different drug tier? Do they have a less enhanced social service? Or do they have less access to transportation?

I don't know exactly what those things are. But this is an area in which what the patient does has a material influence on the success of this therapy and their own productivity. And I think if we are ever going to get into what should the beneficiary do -- if we can't define that, then I would submit to you we have a huge problem of credibility in saying what is that providers' obligation.

DR. WOLTER: On that point, I can't help but remember Jack Rowe standing over there, as he was apt to do, telling us that we were focused on some of the micro aspects around dialysis rather than on the chronic renal failure patient as a whole, and sort of the totality of what goes on in the course of care over a year for somebody in that situation. And could we think about this in a bigger way,

maybe a more bundled way?

So that's what I would mean by patient focused, as opposed to just dialysis or just a graft or just when they're in the hospital. I think we could move that way in other areas too, whether it's congestive heart failure or ICU care or whatever it might be.

I just wanted to -- I can't help myself, having heard all this discussion about the margins. Not all institutions are Pavlovian to an update, whether it goes up or down. And I totally agree, we shouldn't raise an update to deal with a more targeted problem. But I don't think we should lower one for the same reasons. And there are many of us that deliver mental health and geriatric care and are actually trying to provide dental care totally outside what any payment stream has to do with those goals. And just to bring a little balance to this conversation, I think that a lot of that is going on and it should be going on.

MR. HACKBARTH: Okay, Nancy. Thank you.

The final presentation is on home health.

MR. CHRISTMAN: Good morning. I'm going to take you through home health as it relates to our adequacy framework? And we're going to start with access.

In 2006, 99 percent of beneficiaries lived in an area where they were served by at least one home health agency, and 97 percent of beneficiaries lived in an area where they were served by two or more. This should seem like a pretty familiar map. It's similar to what we found in past years, that access to care is pretty widespread.

Next we'll look at the supply of agencies and also, again, a familiar picture. Over the last five years, the number of agencies has increased by about 30 percent and the number of agencies on a per beneficiary basis has increased by about 22 percent in aggregate. This number is still below the peak of 11,000 agencies in 1997, but we are drawing closer to that mark.

The trends in the types of agencies coming in have been pretty consistent across these years. Over 90 percent of them have been for-profit agencies and they've generally been concentrated in a few states like Florida, Texas, and California. I would note that concern about the concentration of these agencies in certain areas has led CMS to launch a fraud demo in Houston and Los Angeles that is requiring home health agencies that operate in those areas to resubmit their paperwork basically to participate in

Medicare and to be subject to additional survey and certification visits from state survey agencies.

For 2007 so far, it appears that the number of agencies is still increasing but it's increasing at a slower rate. For example, in the first 11 months of 2006, the number of agencies has grown by about 7 percent. For the first 11 months of this year, 2007, the number of agencies has increased by about 4 percent. So the number is still going up but it's a little lower. There's a couple of reasons that this could be the case.

One is that CMS has instructed states to focus on complaint investigations and recertifications of existing agencies. Consequently, many states -- including Texas -- have stopped certify new agencies. So agencies that were planning on using the state survey agencies are having to go to the private accrediting organizations.

And also, there been some changes for home health payments that are pretty significant for 2008. Some providers may want to wait out these changes and see how they'll change local markets. I'll explain some of those changes in a few slides. But overall, these trends suggest that supply of providers continues to increase.

Next, we'll look at the trends in volume. The number of users and episodes steadily increased between 2002 and 2005. As you can see on the middle row here, the number of episodes increased by 7.9 percent between 2002 and 2005. But in the last year, 2006, it grew at much lower rate, 1.7 percent. We think some of this slowdown may be attributable to fewer beneficiaries in Medicare fee-for-service as more beneficiaries opted to enroll in Medicare Advantage.

If you look at the top row there, you'll see basically the rate of use, the number of users per 100 fee-for-service beneficiaries. So this adjusts for the shifts in enrollment. You can see actually that the share of users who used home health actually increased even though the episode volume slowed down by one tenth of a percent.

The bottom line shows the episodes per user and you can see that the amount of episodes each user consumed also increased. So while the rate of growth slowed down in 2006, the overall use of the benefit appears to be growing.

Next we're going to look at quality of care. And this table shows risk-adjusted quality measures from Home Health Compare. The top five yellow lines are measures of a beneficiary's functioning. On these, these show the

percentage of beneficiaries who improved on that measure at the end of their home health stay. An upward sloping line indicates improvement. And as you can see, we've seen modest improvement in the last five years.

The two bottom lines, the blue lines, are rates of adverse events, hospitalizations and ER use. A decrease in these lines would indicate improvement. As you can see, these lines have been pretty steady over the last couple of years, with the exception in the last year we have seen a 1 percentage point increase in the rate of hospital admission.

Next, we're going to look at margins for 2006. Overall, the margins for home health providers were 15.4 percent in 2006. The results for the distribution and for the different types of ownership were similar to what we've seen in last years. The agency at the 25th percentile in the margin distribution had a margin of 1.2 percent and the agency at the 75th percentile of that distribution had a margin of 26.2 percent.

The results for geography again were similar to what we've seen before. Those agencies that serve both urban and rural beneficiaries had margins of 17.2 percent while those agencies that served only rural beneficiaries

had the lowest margins, but still their margins were 14.3 percent.

In terms of type of control, again the for-profits had the highest margins of 17.4 percent and the not-for-profits had margins of 11.6 percent.

Next we're going to discuss changes to payments and costs for 2008. Before I talk about the market basket and cost per episodes for 2008, I'm going to lay out two policy changes that affect our margins. The first of those is that CMS has implemented a payment adjustment to account for changes in coding practice that occurred in the home health PPS when it was implemented. CMS looked at the change in case-mix that has occurred between 2000 and 2005 and found that in aggregate it went up by about 13 percent.

They looked at this change and found that 90 percent of it, 11.8 percentage points, was due to changes in the way that agencies were coding their patients and not patient severity. So consequently, they are going to adjust the base rates in the next four years by the amount shown on the screen to bring payment levels down to a level that is commensurate with patient severity. In fact, this adjustment will take out about 2.7 percent a year from the

base rate. The impacts of these are included in our margin estimates.

The other change is that CMS has implemented some major changes to its resource groups to better measure patient severity. The number of resource group has nearly doubled to 153. They have also included an adjustment that will pay higher payments for the later episodes for a beneficiary who has multiple episodes in a home health spell. And they have eliminated the single therapy threshold and replaced it with a system of multiple thresholds that gradually raises payment for therapy. The case-mix weights have been updated to reflect 2005 utilization trends.

Our analysis indicates that these refinements have yielded a modest improvement in accurately. We did some analysis on this last summer and I can explain more during the question session if you're interested.

The important thing for our 2008 margins is that the new system substantially expands the role of coding practices in payment. For example, the number of diagnostic categories that affect payment is expanding from four categories to 22. We expect agencies to change their coding

practices as a result of the new system. And based on CMS's estimates of coding change that I discussed on the previous slide, we anticipate that this will raise their payments by 1.6 percent in 2008.

With those policies, we now turn to the rest of payments and costs for 2008. In 2007, agencies got the full market basket update of 3.3 percent. For 2008, the base rate will increase by about one-quarter of 1 percent, and this is the net impact of two policies: the full market basket update of 3 percent and a 2.75 point reduction for changes for coding practice that occurred between 2000 and 2005.

We found that costs per episode grew by about 2.7 percent in 2006, still lower than the market basket but higher than what we've seen in previous years. With these assumptions, we estimate the margins for 2008 at 11.4 percent.

In summary, we find that access to care continues to be widespread with many beneficiaries having a choice of providers. We continue to see modest improvement on quality. More providers are entering the program and the volume of services continues to increase. Cost growth

continues to be low and with this information, we now turn to a discussion of the draft recommendation for 2008.

This draft recommendation is from last year. It reads the Congress should eliminate the update to payments for home health care services for calendar year 2009.

Spending implications are that this would be a decrease relative to current law. And the beneficiary and provider implications is there would be no adverse impact on beneficiaries expected. It's not expected to affect providers' willingness and ability to care for Medicare beneficiaries.

The next thing, I'm going to lay out some things we're thinking about pursuing next year. Chiefly these come out of our look last summer at the new system, which we think has some improvements in it but still has some problems. Payments will still substantially exceed costs for most services and significant variation exists within the resource groups in the new system.

The two things we'd like to look at are how CMS estimates cost in the home health PPS. It's unique in that they don't use the home health cost reports. Instead, they have a method that relies upon BLS data. And we want to

look at this and see if it is affecting the accuracy of the system.

Also the new system, like its predecessor, appears to pay cases that qualify for extra therapy payments more than cases that do not. We want to look at factors that may be driving these overpayments.

That completes my presentation. I look forward to your questions.

DR. SCANLON: Given that it's Groundhog Day, as I've said before, I think that we have a fundamental issue with this payment system which is that we put out large lump sums of money and we don't have any specification of what we're expecting to get as a response.

I think that's very much reflected in the distribution of margins that we see, that we've got 25 percent of agencies more than 25 percent profit margins. It's also reflected in the growth in terms of the number of agencies. This is another one of the gold rushes that we talked about yesterday. The fact that it's slowing, it's not slowing because somebody thought that the gold has been tarnished so much as perhaps the fact that places like Texas have said we're not going to certify any new agencies for

the moment.

I think we have a very significant problem. Our recommendations in the past have been in the right direction in terms of saying let's not add to this. But at the same time, we should be addressing the problem. And we should be asking ourselves what are we getting for this money? That roughly 15 percent margin, think about the dollars that that 15 percent margin represents. How could they be allocated better in terms of serving these beneficiaries? I think that's what we should be focusing on.

The behavioral adjustment that CMS is going to do, in some respects, even though our recommendations have not all been accepted, is going to create essentially what we've recommended. It's going to reduce that market basket adjustment. And that's a positive. But again, at the end of the spectrum where people are actually trying to serve beneficiaries and therefore might have lower margins, those are the people that are going to be punched more, since at the upper end of the spectrum in terms of margins, people are not potentially concerned about what they're doing, they can accommodate these kinds of increases by further squeezing on services. Because again, we don't have any

definition of what should be happening.

I take no faith or no hope in the quality measures, particularly with rehab. We're talking about a lot of people that would get better anyway. They had surgery, they needed time to recover, they needed some services at home, they were homebound for a period of time but they get better. And those quality measures, to a great extent, capture that. They don't necessarily capture that the care made a difference.

Other than that, I'm very happy.

[Laughter.]

MR. HACKBARTH: So help me, Bill, understand what you would like to see done. You said that you would like to see us redirect the money, this big positive margin, redirect it to reward -- I'm trying to remember the exact phrase -- but what we want to buy here. Part of the problem is measuring exactly what it is we want to buy here. So how do you see this working?

DR. SCANLON: I agree. And knowing what we want to buy here would be an ideal world. Knowing that we got something for what we paid would be a better world than we have today.

And so I think the idea that if we tied some of the payment to the resources that were actually being devoted to care, that that would be an improvement upon what we have now because right now we make a payment simply on the basis of this individual's eligibility and the fact that they got five visits over the course of this episode. The episode price -- and you can correct me if this is wrong -- ranges somewhere between maybe about $1,300 to $1,400 to $6,000? Is that right? So we're talking about this amount of money going for potentially a five visit episode.

MR. HACKBARTH: So what I hear you saying, Bill, is that given the lack of definition around this product and the corresponding difficulty in measuring what we're getting for the money, you would like us to move away from pure episode-based payment to a blended payment system at least, where part of it may be on the per episode basis but part of it is -- pardon the expression -- fee-for-service. We're paying for particular services?

DR. SCANLON: It's either fee-for-service or it's some kind of risk corridor. The other word that's been used is partial capitation, so we could call it partial episode.

The objection in the past has been this involves a

reconciliation. We've just gone through a reconciliation with the Part D plans, if I understand that, on a plan-by-plan basis. So we're talking about a magnitude, in terms of reconciliation, about the same as we would have with respect to home health. And we can do the reconciliation, again not on an individual patient basis but on an agency basis.

At the end of this year did this agency -- should the acceptable margin be 5 percent? And so if an agency is beyond 5 percent, should be asking we don't think that that's appropriate so we're going to recoup this? And 5 percent is just an arbitrary number picked out of the air but it's that kind of a concept.

I think that it involves more administrative resources. But again take the 15 percent times what the total we're spending on home health and ask ourselves are we spending our money wisely?

Would we be better of if we spent some more money on administrative resources and targeted our home health dollars more effectively?

MR. HACKBARTH: An implicit premise here, I think, is that the problems with product definition and measurement in the home health are not short-term, they're really

fundamental. And that needs to be reflected in our payment approach.

DR. SCANLON: I think that's right because what we're talking about is a group of people that need a lot of service. And certainly, home health is not satisfying all of their service needs. If they're homebound, if they're dependent in activities of daily living, a number of them are going to need care many times during the day seven days a week. That's not what home health does. Home health provides some type of supplement to what might be coming from family or might be coming from other sources. And it also has a skill component to it. We don't really have a good grip beyond the skilled component as to what the supportive element is going to be.

If we remember before the PPS was enacted in 1997, that a major component of home health was then aide services. We've seen those disappear to a great extent, but the question is to what extent are aide services an important and a valued component of home health? Have we lost some of that in this process? We don't know that. We don't really understand care for this type of person, particularly the non-recovering kind of person -- I'll

continue to repeat myself -- the deteriorating patient or the permanently stable patient in terms of a person with disabilities who's not going to get better. We don't have a good set of standards in terms of what is the care that that kind of person should receive.

Maybe clinicians do, but I think probably even they would admit that part of that's intuitive. We don't certainly, in a policy world, talk about here are the standards we can use to say this is the care that this kind of person should get.

Medicaid agencies deal with this all the time in their long-term care programs. And if you look at what they do, it varies all over the map. Now they're not motivated by the money as much or in the same way at least, but it varies all over the map in terms of what people in the positions of deciding what care someone get are going to receive. And so we don't have a standard.

MR. HACKBARTH: Let's get some other people in.

MS. HANSEN: Bill has really spoken to the issues. He and I had a conversation before this and so I won't repeat anything except for the piece about looking at what is our ultimate goal? And I'm looking at the slide number

five on quality of care. The two areas that went downward a little bit were the areas of unplanned ER use and hospital readmits.

I just almost wonder if besides the specific clinical issues that at this point are still being evaluated relative to the wound care group and the falls work that was in the chapter, the ability to take a look at these high cost areas actually, that generate more cost to the total system, but it's about the whole episode period rather than the bricks and mortar structure of a home health agency or a hospital.

I wonder if we might look at that the tie as the full episode and it goes back to what Karen and Nick were bringing up. What is the responsibility and what control do you have over the behavior of patients? Is that the behavior? Or is it that period of care?

And that's where the element of the home health aide, whether or not that is what helps stabilize. It's not just doing the therapy, which is right now what's paid for and that's why we see more of that. But it's a combination of appropriate therapy and home health care aides that perhaps stabilize some of this that make a big difference.

So I do think that bottom line is that the metrics have to be looked at more broadly and it may be a full episode of care. But right now, if the light is being shown on payment for more therapy over time, well that's more or less what will get covered and that's what we'll see.

So are we more focused now on any hospital admission or unplanned ER use that would capture both the people who are declining that you're talking about, Bill, but also the people who will get well? So I just think it's a different mental model that really has to looked at on this whole area of home care.

But I do think that this whole payment of what is the margin that's correct and whether or not the redistribution of that money for the quality side eventually would be much better off with right now the quintile that doesn't seem to have much of a margin.

MR. CHRISTMAN: Just to pick up on that point, Jennie, CMS is going to begin next month a home health pay-for-performance demonstration and there are seven measures that are part of that. Like we've talked about before, each one of these measures has its weight when you figure out any incentive. And the adverse event measures are both in there

and they're sort of overweighted. They've been given more significant in determining whether or not an agency would get an incentive payment.

So I think that it is on people's minds, as one direction for the payment system.

MR. EBELER: I am not equipped to comment on the longer-term directions that have been discussed. They sound like the right longer term directions.

When you look at the shorter term, at the increase in supply of agencies, increase in use per fee-for-service beneficiary which each year is small but over time adds up, I almost worry that we're sort of replicating what led up to what Nancy-Ann had to deal with in 1997. It just seems to be this slow -- when I look at then -- so that certainly indicates that our payments are substantial and adequate.

What you look then at the payment levels, the distribution of margins, and the average margins, I find it hard not to say that -- it seems like gee, the lowest update factor you can consider is zero. But the truth is in this field, given what we've talked about, we should be discussing a 5 percent reduction. You just can't look at what's happening here and say -- and calibrating it among

the other things we're talking about, that that's the right number. Pending -- again, I don't know enough to get into the longer-term reform discussion, which also needs to happen, since you clearly need to do that. But it's very hard to look at this in the context of everything else we've looked at and say zero is the lowest possible number.

DR. SCANLON: Jack, I agree with a lot of your concern. But I guess it's this issue of a 5 percent across-the-board change is potentially detrimental to the people that are doing it right. Because one of the things that we also saw in the 1990s before PPS was enacted was the fact that we had this incredible variation in terms of how home health agencies were serving people. Even though they were incentives out there to over-provide, we had agencies that did the same thing they had done 10 years before. They weren't incurring excessive growth, et cetera.

And then we had all of these new agencies that were going up double-digits a year in terms of this. I think that's part of what we're seeing here, too. We have potentially a bimodal, at least, distribution of agencies. And I can't identify them for you go, but we'll have the ones that are behaving responsibly, and the ones that are

potentially not behaving responsibly.

And I think a big cut would hurt the ones behaving responsibly.

MR. EBELER: I'm happy to calibrate that. But much like we see in other areas, whether it's Medicare Advantage payments or other things, we are drawn to payment policies that appropriately try to protect those places that are doing exactly what we want. And as a result -- if we're not careful, as a result of that, a lot of money flows out the door to folks who are doing things that we don't particularly want. There's a point where you simply have to say stop.

MR. HACKBARTH: Unfortunately, they don't wear signs saying "behaving responsibly." Or at least you can't believe them when they wear them.

But what I hear you saying, Bill, is in principle you don't have a problem with rebasing the rates. But you would do it concurrent with a change in the payment structure and not in sequence?

DR. SCANLON: Right.

DR. STUART: I want to make sure that we understand what we see in this slide. I take Bill's point,

that a lot of these people are going to get better anyway.

But if I read this slide, this is saying that over time there's improvement in terms of the average patient -- not within the patient but across patients. So that every patient may be improving, but what this is saying is that the average patient is better off on these self-reported measures, agency reported measures, then they were in the past.

What I'm stuck with in this particular diagram is that all of the agency reported measures of performance are going up. Where, as Jennie has indicated, the reported measures that come independently from claims have stayed the same or maybe even have gone down a little bit.

So I have actually two questions about this. First of all, whether there's any auditing of these OASIS measures? I think I know the answer to that. But it would also then go one step further to say -- I'm not convinced that these are bad measures, by the way. But is there something that would be independent of the agency OASIS report by which these could be verified? In other words, are these things really getting better? Or is this just simply a reporting artifact that we see on behalf of the

agencies? Or perhaps it may be an acuity issue and that there is a change in the case-mix of this patient population over time?

I think that really matters because if, in fact, we were to take these at face value, and we thought that walking and bathing and less pain are important -- which we all do -- then this paints a very different picture than if it's due to some of these other factors.

MR. HACKBARTH: I think some skepticism about the reliability of the measures was the reason for enthusiasm for home health P4P waning somewhat. Bill has made your point several times over the recent years. And I think Bob has also expressed concern about that. So I think that's a real issue. Even?

MR. CHRISTMAN: I guess there's a few points I would note, and that is I'm not aware of any auditing that happens with the OASIS. What does happen is CMS does have a series of programs where they go out and work with agencies who do the evaluations and promote consistent coding practices and those types of things. But it is self-reported.

But this is sort of -- when we're going to do

these sorts of admission and discharge functional assessments in any setting, that's the challenge. The other payment systems may have more thorough ways of working with the industry to make sure that they're being consistent in how they're coding, it's still ultimately the same issue with the IRF and the SNF MDS. They are filling it out and we're not going to be able to check but even a fraction of those if we were to even start to do so.

So it is a question of how much do we want to rely on that data? If you want to measure things, like Bill was pointing out, we buy a lot of therapy. This is a natural way to want to measure it. If you don't think this data works, then you've kind of got to go back.

And so right now what CMS is doing, like in the P4P demo, they're working with what they've got to try and see if we can use that to get a little more value.

MS. BEHROOZI: I think it's that kind of thing that I think last year when we were talking about P4P in home health, some of the discussion was around looking at process or structure measures where outcomes are harder to measure. Maybe that's the kind of thing you need an expert panel to talk about, instead of looking for correlates

between outcomes and certain structures and processes, maybe you need people who -- the good guys -- to get together, the good behaviors, to get together and really come up with a set of meaningful process and structure measures that would be more reliable and could be measured.

DR. KANE: We're doing all the work on episodes and we've done a lot of work on episodes and looking at cost -- when home health is present in some of the these episodes, does it make a difference? I'd like to see can we tell that yet? So if you pick some of the major diagnoses -- I noticed, for instance, that when the IRFs weren't allowed to do the joint anymore unless they were duals that a lot of the people got picked up in home health.

It would nice to see what the episode implications are for the joint replacements. I don't know what the key diagnoses are in home health. But could we take some of those top 10 episodes types and see when there's a home health component as opposed to a SNF or a nothing or an -- and just get a sense of what is the overall -- it's one way of looking at value with what we've got, even though it's not the ideal.

Is it adding value if you have your total hip and

you go home health as opposed to go to outpatient or go to -- I don't know. I think we have the data at this point on the episode -- we've been doing the episode grouper thing for a while. Wouldn't we have the data to highlight, take those types of patients and they what's the home health impact on that? Just to get us started on thinking about what value is.

My only other point is in looking at the history of our recommendations, they are no update for the last five years. That's been listened to once. I guess I'm just trying to get a sense of what why, in fact, they got a 3.3 percent update in 2007 when we said none. In most other years they give them updates. So what is the dynamic that were missing perhaps, that we need to understand better, that we could better address in our conversation about updates?

MR. HACKBARTH: It's not analytic.

[Laughter.]

MR. EBELER: That may be why starting at minus five would get us to a better place.

DR. DEAN: I just wanted to make a quick comment about the whole P4P thing. I look at those last two

measures and it strikes me that one of the basic issues about P4P, if it's going to be workable the entity that's being measured has to have control over the parameter. And it looks to me like both of those are situations where the home health agency could clearly be doing everything they are expected to do. And if they've got an uncooperative or inattentive physician, to be gentle about it, that could lead to both of those things, even though the agency is doing everything properly. I guess I would just caution, I'm not sure those are ideal measures.

MR. HACKBARTH: Here's an other divergent thought. As Bill suggested, maybe the idea of fully per case payment doesn't work for a service like this. I might even take it one step further, that this is not the sort of service that ought to be purchased independently. It ought to be bundled with other services.

Because given the nature of it, it almost seems impossible for a long-distance purchaser like Medicare to be sure what they're buying. At least if it's bundled, you've got a provider, a responsible provider, a group of clinicians on the ground interacting with the organization to make sure that something of value is being produced. It

almost seems to me that it shouldn't be a separate payment category at all.

DR. REISCHAUER: Is there something to be learned by looking at Medicare Advantage plans that are coordinated care plans and saying how much do they use this service? And what kind of provider do they use to offer these services? And maybe what's the outcome?

DR. SCANLON: The issue there, though, is you've got to find the person that you're going to hold accountable and you have to have standards that you can hold them accountable to. The problem in home health, we always have had physician certifications. We actually had to get to the point where we had to create a procedure code to sign the certification.

The question is read, consider, modify, et cetera, the certification. That isn't necessarily what's happening. So I think it's an interesting model but it faces some of the same hurdles that we have with the episode payment, is we really need to work on the definition. And the definition is complicated because the population being served is very heterogeneous. It's something to hold out there for the longer term.

MR. HACKBARTH: Any others?

Okay, thank you, Evan.

We will now have our public comment period. Please identify yourself and keep your comment to no more than a couple of minutes. If you see my red light flash on, you're close to the end at that point.

MS. STINCHCOMB: My name is Stephanie Stinchcomb. I represent the American Neurological Association.

One of our codes was identified as one of the high volume growth. And Dr. Castellanos had alluded to, we would more than be willing to provide any additional information or any assistance when and after you get the information from him to help you understand anything that you may need.

MS. THOMPSON: Hi, this is Kathy Thompson with the Visiting Nurse Association of America.

I just want to comment on the point about the adverse events. I think it was Dr. Dean who raised the question or the issue about whether home health agencies have any impact on those outcomes at all. From what I hear from visiting nurse agencies, nonprofit agencies, is that they have very little influence over those adverse events, especially rehospitalization. It's the physicians who

really call the shots on that.

When it's after hours, not between 9:00 and 5:00, and a patient has a setback, it's the physician that needs to decide whether or not that person goes to the hospital, not the home health agency. And I hear that over and over and over again from visiting nurse agencies, and how it's a real source of frustration on that. It's such a large part of the payment system and on the quality measures.

And if there's any way we can have any discussion over that, that would be great.

Thank you.

MR. HACKBARTH: Okay, thank you very much.

We're adjourned.

[Whereupon, at 11:11 a.m., the meeting was adjourned.]

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