

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 8, 2009  
9:50 a.m.

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

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

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

1 efficient providers when making update recommendations.

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

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

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

17 Access to capital, however, has been volatile in  
18 2008. After a record-breaking \$30 billion in hospital  
19 construction in 2007 and strong municipal bond offerings  
20 last spring, the credit markets rose up in the fall. In the  
21 last two months of the year the bond offerings picked up  
22 somewhat but lenders are demanding higher interest rates on

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

6           The overall Medicare margin declined from a minus  
7 4.7 percent in 2006 to minus 5.9 percent in 2007. Looking  
8 at the distribution of margins across types of providers,  
9 rural and urban PPS hospitals continue to have similar  
10 margins, while major teaching hospitals continue to have  
11 above average Medicare margins.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           The net effect of this recommendation is that



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

6 Craig will now talk about the indirect medical  
7 education payments.

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

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

15 Analysis we conducted for our 2007 March report  
16 showed that inpatient costs in teaching hospitals increased  
17 2.2 percent for each 10 percent increment in teaching  
18 intensity, but the adjustment is set so that payments  
19 increased by 5.5 percent, resulting in a \$3 billion subsidy  
20 to teaching hospitals with no direction or accountability  
21 for how these funds are to be used.

22 The size up the subsidy can be substantial. The

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

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

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

10           For the last two years, the Commission has  
11     recommended that the IME adjustment be reduced by one  
12     percentage point to 4.5 percent. At the Commission meeting,  
13     several alternative options were discussed, but after some  
14     additional discussion, the Chair is proposing that we repeat  
15     last year's recommendation, which reads: The Congress  
16     should reduce the indirect medical education adjustment in  
17     2010 by one percentage point to 4.5 percent per 10 percent  
18     increment in the resident-to-bed ratio. The funds obtained  
19     by reducing the IME adjustment should be used to fund a  
20     quality incentive payment program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19           DR. BORMAN: Just ballpark order of magnitude  
20 difference?

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

3 DR. KANE: Do we have a sense -- maybe I should  
4 ask Peter -- what's a meaningful quality incentive to really  
5 make hospitals feel that this is worth responding to? Is it  
6 2 percent? Is it 3 percent? Is there any work done on that  
7 to address what's a meaningful amount?

8 MR. BUTLER: First, I'm supportive of quality  
9 payments. Any percent makes a difference. We are  
10 competitive organizations and when you put scorecards in  
11 front of us, we respond, even in the absence of any payment  
12 at all, the core measures have moved along nicely in terms  
13 of what's occurred. So, any percent makes a difference and  
14 1 or 2 percent sounds small, but it's a big number. And  
15 it's the right size to get started. It's plenty.

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

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

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

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

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

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

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

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

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

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

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

7           DR. STENSLAND: I didn't take these hospitals and  
8 project what their specific margin would be in 2009, given  
9 2010 policies. But given the breakdown, it's going to  
10 probably, on average, about a half percent lower, so maybe a  
11 minus 0.5 percent. That would be a guess.

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

19           DR. KANE: So if we're trying to think about what  
20 the projected margin of an efficient hospital provider in  
21 2009, we're talking breakeven or possibly a little below  
22 breakeven, in considering what the update should be.

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

3 DR. KANE: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 DR. STENSLAND: Right.

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

16 DR. STENSLAND: Right.

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

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



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

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

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

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

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

5           MR. GEORGE MILLER: Yeah, disabled. Okay.

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

11          DR. STENSLAND: What we did is we --

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

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

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

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

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

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

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

4 MR. GEORGE MILLER: And higher Medicare margins.

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

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

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

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

16 MR. GEORGE MILLER: Correct.

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

20 MR. GEORGE MILLER: Got it.

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

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

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

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

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

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

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

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

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

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

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

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

18 DR. STENSLAND: Okay.

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

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

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

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

15 DR. STENSLAND: Right, and the quality.

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

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



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

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

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

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

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

16 MR. GEORGE MILLER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. GEORGE MILLER: Medicare margin, right.

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

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

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



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

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

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

1 going up or down a.

2 MR. GEORGE MILLER: By definition. Okay.

3 MR. BUTLER: One statement just on the data, and I  
4 think I said this last month: The IME reduction, just to  
5 clarify, is not a 1 percent reduction, really it's about a  
6 20 percent reduction in IME payments. And so, major  
7 teaching hospitals under this recommendation would get about  
8 a zero increase given the market basket. It's about zero  
9 for major teaching hospitals next year, when you take the  
10 market basket and you pull out the IME, that's about where  
11 it is. And it takes them into negative territory in terms  
12 of the projected Medicare bottom line; correct?

13 MR. LISK: That's about right.

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

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

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

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

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

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

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

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

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

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

10           Recommendation two. Opposed? Abstentions? In  
11 favor?

12           Okay, thank you very much.

13           Next is physician services.

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

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

1 on a recommendation for that.

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

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

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

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

1 these appointment measures.

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

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

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

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

1 question. I note that methodologically, our data on incomes  
2 do not include asset information. Therefore, it's difficult  
3 to compare measures on wealth, say, among Medicare  
4 beneficiaries, many of whom are retired, to the 50- to  
5 64-year-old population. Also, the low number of categorical  
6 variables on the demographic portion of the survey do not  
7 adequately distinguish levels for our purposes. So for  
8 these reasons, we really only saw a couple clear  
9 correlations and I will note them here.

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

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

22           So a possible rationale for this finding is that



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

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

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

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

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

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

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

15           So on to the second part of our adequacy  
16 framework, which is changes in costs for 2010, CMS's  
17 preliminary forecast for input price inflation is 2.4  
18 percent. Within that total, CMS sorts the inputs into two  
19 major categories, physician compensation expected to  
20 increase by 2.8 percent, and physician practice expense by  
21 1.9 percent. Calculated from BLS statistics, our analysis  
22 of trends and multi-factor productivity suggests a goal of

1 1.3 percent across all sectors.

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

7           So combined, two changes in the physician fee  
8 schedule have increased payments for primary care by about  
9 10.6 percent. The first is the 2007 review of the fee  
10 schedule's work RVUs. On average, CMS increased the work  
11 RVUs for primary care services by about 26 percent. For the  
12 most frequently billed E&M service, the work portion  
13 constitutes a little bit more than half the total payment  
14 for that service.

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

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

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

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

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

1 of the recommendation.

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

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

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

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

22 Take it away, Ariel.

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

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

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

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

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

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

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

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

22           We propose that CMS start by adopting a 45-hour



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

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

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

1 smaller than shown here.

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

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

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

1 2010 and smaller reductions in subsequent years.

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

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

10           MR. HACKBARTH: Thank you. Could I ask a  
11 clarifying question of Cristina, and it has to do with slide  
12 9, Cristina. Could you explain the 10.6 percent again, what  
13 that means? I missed that.

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

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

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

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

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

10 MS. BOCCUTI: We discussed both a 5 percent and a  
11 10 percent and we looked at some impacts for both of those.  
12 But in the recommendation, we just said an increase in the  
13 language. Does that answer your question?

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

19 MS. BOCCUTI: Yes.

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

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

1 adopted. So the 10.6 is what is being adopted.

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

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

9 MR. HACKBARTH: If it were 10 percent.

10 MS. BOCCUTI: Yes.

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

13 MS. BOCCUTI: Right.

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

16 MS. BOCCUTI: And those, right.

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

1 payment.

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

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

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

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

22 Now clarifying questions, other clarifying

1 questions.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

13 The other one is the e-prescribing bonus, and that  
14 also is voluntary and that will go through 2009 and 2010,  
15 and then the bonus ratchets down in subsequent years to the  
16 point -- I have been numbers here, but I am guessing it is  
17 2013 where it starts to be a negative if you don't submit in  
18 electronic prescribing. Then there could be a negative  
19 affect on the payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 DR. KANE: I understand.

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

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

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

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

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

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

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

1 did they?

2 MS. BOCCUTI: No, you're right.

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

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

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



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

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

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

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

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

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

14 DR. KANE: That's what I thought.

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

1 back into the physician fee schedule.

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

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

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

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

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

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

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

1 DR. CASTELLANOS: How about to the hospitals?

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

5 DR. CASTELLANOS: Why?

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

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

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

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

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

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

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

3 MR. HACKBARTH: We can include those.

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

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

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

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

15 DR. MARK MILLER: And that was new money?

16 MS. BOCCUTI: Yes.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

1 consider the supply costs as well as the equipment costs.

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

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

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

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

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

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

1 MR. GEORGE MILLER: All right. Thank you.

2 MR. HACKBARTH: Any other clarifying questions?

3 Any other questions at all? We're not going to have time

4 for a round three, so let me just see those hands again.

5 We've got a lot. Well, I suppose the sooner we get started,

6 the sooner we will get finished, right, so let me see the

7 hands on this side again and we will just go down the row.

8 MR. BUTLER: Just a comment. We have alluded to

9 e-prescribing a couple of times and we also read in the

10 paper the stimulus package could have \$25 billion for

11 electronic health records and these kind of things. As you

12 invest in health care IT, the productivity pick up and the

13 gains are large around variation in care, utilization, and

14 other things. They are not in the doctor's office.

15 My point is, in a way, we have, I think, given not

16 enough attention to the impact of IT in the physician's

17 office. You're never going to have greater productivity, I

18 don't think, because of it. So it's more, Glenn, as we go

19 forward in health reform in our June report, is that another

20 opportunity to comment on this particular issue, because I

21 think it is a very, very significant opportunity, but also

22 an additional burden and a big part of the productivity

1 question.

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

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

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

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

1 low-income people who weren't previously.

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

12           I don't know how much of that is because of cost  
13 concerns, but obviously you're finding some evidence that  
14 cost concerns have a lot to do with it. And seeing that  
15 twice as many African-Americans -- 14 percent as opposed to  
16 7 percent -- are not seeking care, to the extent that race  
17 is a proxy for income, I think it's something that we should  
18 start paying more attention to as we go forward and not just  
19 physician supply being determined by -- I'm sorry, access  
20 being a question of physician supply.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

10 MS. BOCCUTI: He's nodding.

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

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

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

1 viable option.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 going for the level of utilization across the country.  
2 We're working off of medians and means and making a 25- to  
3 45-hour increase. So I think we can have that as the  
4 standard in terms of when typical utilization is much  
5 higher, we need to raise the utilization assumption.

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

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

1 that they're reflecting actual experience.

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

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

18           [Laughter.]

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

22           I have support for the second recommendation, but



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1           MR. HACKBARTH: Now, in your lead-in, it sounded  
2 to me like your problem is with the productivity language as  
3 much as anything. What if, as alternative, we were to say  
4 1.1 percent, which is the projected increase, minus  
5 productivity, drop the productivity language? Is it 1.3? I  
6 misstated.

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

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

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

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

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

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

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

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

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

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

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

12 DR. CROSSON: Well, we are, yes.

13 MR. HACKBARTH: What is your bottom-line?

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

16 [Laughter.]

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

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

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

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

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



1 things.

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MR. HACKBARTH: I have Mike and Bob and Nancy, and  
15 let's just do a time check. It's 12:15. We were scheduled  
16 to end the morning session at 12:15 and begin the public  
17 comment period. For logistical reasons having to do with  
18 the building management, we have got to break for lunch at  
19 1:00, so we've got 45 minutes to complete this conversation  
20 and also knock off ASCs. So obviously we're going to have  
21 to come back to Jay's proposal and have some more discussion  
22 about that. So I'd just ask people to keep in mind we're up

1 against the time lines.

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

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

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

22 The second point I want to make is recommendation

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

16           [No response.]

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

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

22           MR. HACKBARTH: No --

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

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

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

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

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

14 MR. HACKBARTH: Okay.

15 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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



1 payment rate.

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

10           The revised payment system also presents some new  
11 opportunities for ASCs. In particular, 86 percent of  
12 procedures that are covered under the ASC Payment System in  
13 2007 now have higher payment rates under the revised system.  
14 In addition, as I mentioned earlier, there has been a 32-  
15 percent increase in the number of procedures covered under  
16 the revised system versus the old system. Also, ASCs can  
17 now receive separate payment for many ancillaries that used  
18 to be packaged with the associated surgical services.

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

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

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

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

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

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

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

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

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

8           For example, from 2002 through 2007, the number of  
9 ASC services per fee-for-service beneficiary has increased  
10 by an average rate of 9.8 percent per year, and the number  
11 of Medicare beneficiaries served in ASCs has increased by  
12 7.5 percent per year.

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

18           In addition, the number of ASCs has increased by  
19 an average of 266 facilities per year, which translates to  
20 an average annual growth rate of 6.7 percent. Moreover, we  
21 estimate that the number of ASCs has continued to grow into  
22 2008 as the number of Medicare-certified ASCs has increased

1 by 166 from the start of 2008 through the third quarter of  
2 2008.

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

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

22 Now, an important issue regarding ASCs is that, in

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

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

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

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

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

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

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

5 That concludes our presentation.

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



1 which makes it undesirable as a basis for payment policy.

2           So I am recommending we do two things. One is in  
3 this recommendation fix the number at the current estimated  
4 difference between -- or the current estimated amount for  
5 the statutory CPI-U measure minus productivity, and that is  
6 0.6. The second thing I recommend is that, not today but in  
7 the future, we take up what would be a more appropriate  
8 market basket for the ASC Payment System. I don't think it  
9 needs to be a huge issue. There are some candidates that  
10 are out there from other provider types, but I just didn't  
11 want to do that too hastily and do it on a few minutes'  
12 thought. I just wanted to give the staff an opportunity to  
13 sort of think through what the best of the alternatives  
14 would be. And, you know, potentially, we could come back  
15 and vote on that for inclusion in the June report, and so we  
16 will have a two-part change in ASCs. So that is the  
17 thinking behind the difference between this recommendation  
18 and the one you saw in December.

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

21           MR. BUTLER: A question on the chapter. On page  
22 64 you have a chart that shows the ownership, whether they

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

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

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

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

22           Regarding the specific number in Table 2, which

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. CHERNEW: [off microphone] [inaudible]

14 DR. REISCHAUER: [off microphone] [inaudible]

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

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

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

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

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

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

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

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

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

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

5 MR. HACKBARTH: Round two questions.

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

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

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



1 I am comfortable with the recommendation.

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

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

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

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

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

1 you have the information.

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

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

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

15           MR. HACKBARTH: Any others?

16           DR. ZABINSKI: A quick answer to Bob's earlier  
17 question on this. It would be actually somewhere in between  
18 9.8 and 3.5. It would be a weighted average of whatever the  
19 HOPD volume is versus what the ASC volume is. So it would  
20 be closer to 3.5 percent than 9.8.

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

1 beneficiaries who go to the ASC, and how --

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

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

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

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

11 [Laughter.]

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

14 All opposed to the recommendation? Abstentions?

15 All in favor?

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

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

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

6 Sharon McIlrath with the AMA.

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

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

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

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

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

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

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

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

11 Just about five years ago, ASCs were paid -- about  
12 86 percent of HOPD payments for providing the identical  
13 services. Because of the six-year freeze and subsequent  
14 cuts in the DRA, they are now down to 59 percent, and I  
15 think we're getting to the point that services may be  
16 unsustainable at that level, and 0.6 percent, while it's  
17 better than a freeze, is still pretty low.

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

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

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

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



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

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

8 Thank you.

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

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

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## AFTERNOON SESSION

[2:02 P.M.]

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Second, with respect to facilities that closed,  
12 some of what we found is intuitive. Facilities that closed  
13 are more likely to be smaller and less profitable than those  
14 that remained in business. This year we do not see the  
15 differences in patient characteristics in the facilities  
16 that closed compared with those that were in business in  
17 2006 and 2007.

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

21 [Laughter.]

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

1 here is complete.

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

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

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

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

1 analyzing claims at the beneficiary level.

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

7           Moving onto changes in the volume of services. I  
8 just want to point out one item here. We do find this year  
9 a small decrease in the per treatment use of epo between  
10 2004 in 2007. The changes in epo use are related to changes  
11 in law and regulation and how Medicare pays for dialysis  
12 drugs. In addition, there have been recent studies that  
13 were published in peer review that showed the risks of too  
14 much of erythropoietin.

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

22           In addition, the revised chapter includes a text



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

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

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

9 The number of kidney transplantations in the  
10 United States has steadily increased, surpassing 18,000 in  
11 2006, the most recent year of available data. Demand for  
12 kidney transplants seems to outpace supply. While the  
13 number of transplantations increased by 4 percent from 2005  
14 to 2006, the number of patients on the waiting list grew by  
15 8 percent in the same time period.

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

1 benefit for 36 months following a transplant.

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

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

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

1 counterparts.

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

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

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

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

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

1 There are three reasons for this result.

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

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

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

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

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

1 which is 1.3 percent for our 2010 deliberations.

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

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

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

3 MR. HACKBARTH: Thank you, Nancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Nancy.

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

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

19 Any questions about that or clarifications needed?

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



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

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

5 MR. HACKBARTH: Yes.

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

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

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

15 MR. HACKBARTH: Yes.

16 MR. BUTLER: Yes.

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

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

22 All of those opposed to the recommendation? All

1 in favor? Abstentions?

2 Okay. Thank you very much.

3 MR. HACKBARTH: Next is skilled nursing  
4 facilities.

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

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

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

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

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

1 Jennie mentioned about the impact on beneficiaries. And  
2 this is, in my mind, a major issue on impact on  
3 beneficiaries where Afro-Americans and other minorities are  
4 3.5 times more likely to have end stage renal disease, but  
5 yet to not get placed on the facility.

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

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

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

21 Thank you, Nancy, for waking me up.

22 Anything else people want to say specifically

1 dialysis?

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

5 MR. HACKBARTH: Yes.

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

9 MR. HACKBARTH: Absolutely. Yes.

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

18 MR. HACKBARTH: Yes, it does.

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

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

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

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

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

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

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

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

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

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

6 Carol.

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

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

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

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

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

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

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

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

22           First, we see a growing concentration of special



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

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

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

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

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

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

13           Karen, you asked about the total facility margins  
14 and I've included those in the chapter. In 2007, the  
15 aggregate total facility margin was 2.4 percent. At the  
16 last meeting, we discussed the reasons why using Medicare  
17 payments to cross subsidize Medicaid payments is  
18 inadvisable.

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

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

4 This leads us to the Chairman's draft  
5 recommendation. The Congress should eliminate the update to  
6 payment rates for skilled nursing facilities services for  
7 2010.

8 Our rationale is consistent with the  
9 recommendations from previous years: Margins continue to  
10 exceed 10 percent and are more than adequate to accommodate  
11 the expected cost growth. This recommendation would lower  
12 program spending relative to current law by \$250 million to  
13 \$750 million for Fiscal Year 2010 and by \$5 billion to \$10  
14 billion over five years. It is not expected to impact  
15 beneficiaries or providers' willingness or ability to care  
16 for Medicare beneficiaries.

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

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

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

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

14           MR. HACKBARTH: Clarifying questions for Carol?

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

17           DR. CARTER: Four.

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

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

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

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

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

15 Okay, thank you very much.

16 Next is home health.

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

1 recommendations.

2           First up is access and supply, and as in previous  
3 years, the supply of providers and access to home health is  
4 pretty good: 99 percent of beneficiaries live in an area  
5 served by one home health agency; 97 percent live in an area  
6 served by two or more. The number of agencies was over  
7 9,700 by the end of 2008, about a 4 percent increase over  
8 2007. Since 2003, the number of agencies has increased by  
9 about a third, or an additional 2,400 agencies.

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

17           Use of the home health benefit has increased  
18 significantly in the last five years. The number of users  
19 has increased to 3.1 million in 2007, which equals about 9  
20 percent of fee-for-service beneficiaries. The number of  
21 episodes has risen 41 percent since 2002 to 5.8 million in  
22 2007. The episodes per user have also risen, implying that

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

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

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

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

1 credit market has not affected them significantly.

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

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

22           This next table shows risk-adjusted quality



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

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

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

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

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

1 areas had the lowest margins, but those margins were still  
2 14 percent. For-profit margins equaled 18.6 percent, and  
3 the not-for-profits were 11.9 percent. And I would note  
4 that in our margin projections that I am about to walk you  
5 through for 2009, we only project margins for free-standing  
6 providers. Hospital-based providers whose margins were  
7 included in those reported during the review of hospital  
8 payments earlier today averaged a margin of negative 4.5  
9 percent in 2007.

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

12           There are two policy changes for 2009 that we need  
13 to include in our modeling. The first of these is a payment  
14 adjustment for changes in coding practice since PPS was  
15 implemented in 2000. This policy will decrease payment.  
16 CMS found that almost all of the change in case-mix between  
17 2000 and 2005 was for reasons related to changes in coding  
18 practice, not changes in patient severity. As a result,  
19 they are lowering payments in 2008 through 2011 to bring  
20 payments down. The reductions for 2008 and 2009 have been  
21 implemented, and additional reductions totaling about 5.5  
22 percent are planned for 2010 and 2011.

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

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

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

7           In the past, the Commission has recommended no  
8 market basket update when reviewing these indicators.  
9 However, the consistently high margins of home health  
10 providers raise questions about the adequacy of this  
11 approach. Since 2002, home health margins have averaged  
12 16.5 percent. These margins have remained high despite  
13 numerous adjustments to the market basket. In 2002 through  
14 2005, the market basket update was reduced on average by  
15 about a point each year. And in 2006, it was eliminated  
16 entirely.

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

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

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

9 When setting the initial rates for the PPS, CMS  
10 relied upon data about the number of visits that occurred in  
11 1998 when the IPS was in effect, which equaled 31.6 visits.  
12 However, the average number of visits dropped between 1998  
13 and the implementation of PPS to about 21.8 visits, which is  
14 about equal to the 22 visits provided on average in 2007.

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

22 The assumption of more visits results in a much

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

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

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

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

12           This brings me to the draft recommendation for  
13 2010. Because rebasing the actual cost would significantly  
14 change payments, our draft recommendations do this is an  
15 approach that spreads the change over two years.

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

1 read the recommendation.

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

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

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

22           Now, we expect that a change of this magnitude



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

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

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

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

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

9 That completes my presentation.

10 MR. HACKBARTH: Thank you, Evan.

11 Clarifying questions for Evan?

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

14 MR. CHRISTMAN: I believe it is somewhere around  
15 30 or 40 percent.

16 MR. GEORGE MILLER: Is there any reason in the  
17 recommendations that we could not change recommendation  
18 draft two to read, to rebase the rates for home care to  
19 2010? Is there any technical reason we couldn't do that,  
20 from 2001?

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

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

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

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

14 MR. GEORGE MILLER: Is there a technical reason  
15 why we could not rebase, set the rate in 2010 instead of  
16 2011?

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

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

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

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

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

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

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

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

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

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

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

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

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

1 product definition of what exactly we are buying.

2 Bill, what do you think about that?

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

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

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

11 MR. CHRISTMAN: Yes.

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

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

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

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

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

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



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

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

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

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

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

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

13 MR. HACKBARTH: Round two, questions and comments.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 troubled me.

2           Just one comment about these numbers. The largest  
3 reductions have been in home health aide and social work  
4 visits. There was a point in time when there was a lot of  
5 concern that the home health benefit was becoming a de facto  
6 sort of long-term care benefit, and that too much of the  
7 activity was not the therapy or skilled nursing, but home  
8 health aide and the like. And so some people might look at  
9 these numbers and say, well, this is actually an appropriate  
10 readjustment of the sort of care, a desirable readjustment,  
11 as opposed to gaming activity. So I think you need to be a  
12 little bit careful I how you assess them.

13           DR. SCANLON: I agree with you on that point to an  
14 extent, but, again, it is this question of sort of looking  
15 at an average overlooks the fact that we are talking within  
16 home health about basically at least two populations.

17           One is the therapy sort of patient who should be  
18 getting better, the expectation is, and more of them are  
19 being served through home health, and that is potentially a  
20 very good thing.

21           The second is this very debilitated, sort of  
22 potentially deteriorating, potentially dying sort of

1 patient, different than hospice. And the question is how  
2 much skilled nursing or how much home health aide should  
3 they be getting, and we don't have any standards for that.  
4 And we don't really have good measures in terms of their  
5 outcomes either. The best we have is hospitalizations, and  
6 there our measures are distorted by the fact that they are  
7 mixed in with the people that are getting therapy. So we  
8 have got to start to think about segmenting this population  
9 to truly understand it.

10 DR. STUART: I share Bill's concern, and actually  
11 it is a question for Evan. It is a little hard to divide  
12 this population of providers into caregivers and gamers.  
13 Even though I agree with you in general terms, obviously  
14 there is some allusion over those two.

15 My question is: Have you looked at the impact of  
16 recommendation one and recommendation two on the for-profit  
17 versus not-for-profit?

18 MR. CHRISTMAN: Well, I think the point I guess I  
19 would note is that the not-for-profits in this area still do  
20 pretty well. They have margins of almost 12 percent, which  
21 is higher than the for-profits in some sectors. And I think  
22 that the thing that is difficult to anticipate about our

1 recommendations is that this industry hasn't been,  
2 relatively speaking, under that much cost pressure for the  
3 last seven years because our payments have been so high. So  
4 we could look at this and say that they have below -- you  
5 know, their margins are below 16.6 percent, so their margins  
6 will be pushed yet lower by our recommendations relative to  
7 the other providers. But we don't know about what they will  
8 do in response because, you know, the slide we just had up,  
9 you saw that visits dropped by 30 percent.

10 Certainly there have been changes in the last  
11 seven or eight years that, if this industry does find itself  
12 under some cost pressure, they may be able to implement to  
13 bring down their costs. So it is true that if we are doing  
14 an across-the-board cut and not-for-profits are on the low  
15 end of the -- or lower relative to the for-profits, that  
16 they will get pushed down more. But whether they wind up at  
17 an inadequate level is something else.

18 DR. STUART: I wasn't speaking about the mean. I  
19 mean, it is obvious that if you take 8 from 11, I mean, I  
20 can compute that. It is more on the distribution. So if  
21 you were to look at the distribution of not-for-profits  
22 around that mean, would there be a significant number of



1 agencies that would be at high cost risk?

2 MR. CHRISTMAN: I haven't looked at the not-for-  
3 profits themselves. I guess what I have done is I have  
4 looked at the margins of providers with negative margins,  
5 and that group, basically it is pretty proportionate to what  
6 you see there. It is not disproportionately urban, rural,  
7 or mixed, or for-profit or not-for-profit. It is pretty  
8 proportionate. The only characteristic that I've seen so  
9 far that sticks out is that the agencies with lower margins,  
10 the higher proportion of negative margins, tend to be  
11 smaller. That is it. But, to my knowledge, the not-for-  
12 profits are not a disproportionate number of the low-margin  
13 agencies.

14 MS. BEHROOZI: I guess I just was going to say  
15 something about the low end, actually, that you were just  
16 talking about, Evan, and that Bill talks about, what are the  
17 characteristics in terms of what we want to get out of the  
18 benefit at the various ends. And I just wanted to highlight  
19 that, you know, comparing it to the last presentation -- and  
20 I know we do these things in silos, and it is kind of hard  
21 to compare across the silos, not necessarily apples to  
22 apples. But, you know, the average margin in SNFs was 14.5;

1 here it is 16.6. But at the low end, at the 25th percentile  
2 in SNFs, it was 5.2. And here at the low end it is 3.1.  
3 And, again, given that we don't know what we are getting at  
4 that low end, I am very concerned about accelerating the  
5 whack, kind of, you know, the take-back on the coding issue.

6 But, having said that, I really love  
7 recommendations two and three, and particularly three, which  
8 I think is the kind of thing, the kind of direction that I  
9 hope we continue to move in with respect to all of our  
10 update recommendations, which is really what is the best way  
11 to spend taxpayer dollars on health care. You know, it  
12 shouldn't be for too much profit, and it shouldn't be  
13 driving the good providers who are providing a lot of  
14 service out of business. I really like the corridor concept  
15 -- thank you, Bill -- in recommendation three. So I am only  
16 comfortable with recommendation one, I think, coupled with  
17 this broader approach, and I really want to commend the  
18 staff and all the Commissioners who have been working on  
19 this for a long time for, you know, coming up with that  
20 broader view and encourage us to do it elsewhere.

21 MR. BUTLER: This is between a round one and a  
22 round two, really, but slide 6 says that these are the

1 Medicare margins. We don't have or I don't think we've seen  
2 anything presented -- this is about, as you guessed, 40  
3 percent of their business. We haven't seen anything  
4 specifically on total margins, right? Okay. So maybe  
5 recommendation three covers this, but maybe it doesn't.

6           In recommendation two, if you put that, and if you  
7 read the chapter, it basically says we are going to set this  
8 at the actual cost. It doesn't just say it will take into  
9 account the cost in rebasing it. It says you are basically  
10 going to have a zero margin. At least that is the way the  
11 chapter reads.

12           So I don't know at this point in time what that  
13 means to the impact on the business as a whole. So I think  
14 the recommendation would be more likely -- and I realize we  
15 focus on Medicare, not the total business. Yet if you are  
16 trying to worry about the access issue, to leap all the way  
17 to say zero profit is the right goal, I would rather have it  
18 say something like we will take into account the costs using  
19 rebasing, or something like that, as opposed to say it is  
20 just zero profit no matter what. Because we are pretty  
21 specific about, I think, that being the recommendation,  
22 using the rebasing. At least the chapter reads that way.

1 If you say just reflects the average cost, and that is not  
2 saying sets it at the actual cost, I would buy it. But I  
3 think it would be better if you just said takes into account  
4 the average cost using rebasing.

5 I know it is a subtlety, but it is a little  
6 different message, I think, at this time than just saying it  
7 ought to be zero profit.

8 DR. MARK MILLER: The thing I would maybe look for  
9 your reaction to, like every other PPS system or most other  
10 PPS systems, when they get to being created, there is sort  
11 of a sense of setting it at an average with an understanding  
12 that there is a distribution because, remember, we are  
13 talking about an average margin of -- now I am even  
14 forgetting -- 12, 15? And, you know, we have a distribution  
15 here, both high and low.

16 So if you are saying, okay, we will set it above  
17 the average, you are also saying that there are people who  
18 right now under the current payment system are earning, you  
19 know, margins that are in the 20- and 30-percent range.

20 So it is fairly standard when you go into a PPS  
21 situation to say, okay, I am going to set it at the average,  
22 I am trying to drive behavior around that average to get

1 people to work towards that average.

2 I do see what you are saying, and I would argue  
3 that even with the reflect, you know, we obviously brief CMS  
4 and other people on all this stuff before we do it, and they  
5 were asking questions, you know: When you talk about  
6 rebasing, what do you mean? You know, what kinds of  
7 factors? And I don't think we are saying there is one  
8 calculation and you rebase and you are done. There are  
9 things that can be considered here in terms of changes in  
10 the mix of patients over time. I don't think we are sort of  
11 rigidly saying only the average cost. But I would throw  
12 that out.

13 MR. BUTLER: Just one minor rebuttal. The chapter  
14 does say it will be set at the cost specifically.

15 MR. HACKBARTH: That's what I was going to get at.

16 MR. BUTLER: I just think there's a little bit  
17 more wiggle room than that. Not a lot.

18 MR. HACKBARTH: So what I hear you saying, Mark,  
19 is that reflect was chosen with care to suggest something --  
20 it is not necessarily just as arithmetic calculation of what  
21 is the average and we rebase at that. And if I heard you  
22 correct, if that is the language in the recommendation, then

1 the text ought to use the same language and be consistent.

2 DR. MARK MILLER: [off microphone] Before you get  
3 too much further down this road -- given the language  
4 difference between what you are pointing to and the text,  
5 maybe, Evan, do you want to comment?

6 MR. CHRISTMAN: Yes. I think that this  
7 conversation has landed in the right place. Perhaps the  
8 language I used in the text was just a little bit too  
9 precise. I think the intent is that ultimately the  
10 Secretary will come up with an estimate of what the cost of  
11 care would be in 2011 based on the most current information  
12 they had and a reasonable guess about how the benefit may  
13 change. So it wasn't intended to be -- we recognize that we  
14 don't want to lock them into some sort of strict formula,  
15 and that is not the intent of this recommendation.

16 MR. BUTLER: Again, if we just stuck to our  
17 principle, like in what we just did on SNF, we would say,  
18 okay, not only are we freezing it, we are rolling it back 14  
19 percent, or whatever, 12 percent. And, you know, we are not  
20 doing that because we are taking the big picture into  
21 consideration to some extent. I would like to think that we  
22 would be looking at the access issue at the same time we are

1 looking at the rebasing. But I am sleeping better over it,  
2 though.

3 MR. EBELER: The points have been made. Just I am  
4 supportive of the three-part recommendation. I think they  
5 tie together well. I think at the core it is rebasing with  
6 an interim adjustment in 2010 so that 2011 rebasing isn't a  
7 huge cliff. And then three is the longer-term policy  
8 recommendation, and I think Bill's point that you want to  
9 begin moving that way sooner, you don't want to wait until  
10 2012 before thinking about that, I think is well taken.

11 DR. DEAN: I think probably some of my concerns  
12 have been answered. I, too, was just looking at that 3.1,  
13 and I wondered if you had the characteristics, if there was  
14 any pattern of the agencies that were in that group. And I  
15 guess I was particularly concerned because in my area,  
16 agencies tend to be very small, and they tend to serve  
17 patients in a very widely dispersed area, so their costs are  
18 high. I mean, they may go 20, 30 miles between patients,  
19 and so their costs are clearly going to be high, and their  
20 margins are going to be low.

21 I guess I would just hope that -- sure, the number  
22 for rural is listed at 14 percent, but there is rural and

1 then there is rural. And anybody that has struggled with  
2 trying to figure out what the definition of rural is will  
3 know that there is no reliable definition because usually it  
4 is non-MSA, and when you get into western South Dakota, you  
5 can go 10 miles between one farm to the next.

6           So it can be a real challenge to deliver some of  
7 these services, and I just would like to be sure that if  
8 there is an agency that is really doing that and, in Bill's  
9 terms, are really giving care, that they are somehow  
10 protected here. But I understand. Basically I support the  
11 recommendation. It is just I think we need to have some  
12 caution because there could be some very valuable services  
13 that get hurt if we get too aggressive.

14           MR. CHRISTMAN: I think I would just say what I  
15 said in response earlier, that it is generally the smaller  
16 agencies, you are right; but it is not disproportionately  
17 rural/urban. This is not one of those situations where one  
18 group dominates like that.

19           MS. HANSEN: Thank you. Thanks, Evan, for  
20 bringing along this far, and my comments are twofold -- one  
21 relative to the recommendations, another one to work to be  
22 done.



1           Again, I really appreciate, especially -- all  
2 three, but I think Bill and the staff having come up with  
3 this whole way of really looking at protecting the care, the  
4 actual providers that is reflected in recommendation number  
5 three.

6           I am thinking about the other thing that, Bill,  
7 you asked for that I want to underscore again, and that is  
8 the kinds of patient groups that do show up for needed home  
9 health care. One is the therapy group that does get better,  
10 and then so much more. And as many of you are aware, one of  
11 my big themes is making sure that people with complex needs  
12 are cared for appropriately.

13           So when I look at the quality-of-care measures  
14 that have improved over time, you know, on page 5, and then  
15 the comments that have been made relative to the types of  
16 skilled visits, on slide 11, the ability to figure out,  
17 again, what the outcomes might be for different kinds of  
18 groups of patients. And so I don't know that it is so  
19 grossly separated to the bolus of people who are more rehab  
20 oriented as compared to people who have a great deal of  
21 medical complexity that in some ways will -- sometimes may  
22 border into the quality metrics of some hospice-like

1 patients. So, you know, I know we are moving to another  
2 silo, but if there is a way that we can begin to think of  
3 what are the outcomes that we would expect for quality for  
4 the different nature of patients, if more work, you know, is  
5 going on in the field itself, that can then begin to get  
6 reflected. But it has to do with how do you measure  
7 appropriateness and outcomes for different populations.

8 MR. CHRISTMAN: I think I would just say one thing  
9 in that there is some work underway in this area that is  
10 looking at different -- like you are talking about, a  
11 chronic care group versus a rehab group and so on and so  
12 forth in terms of those measures. And we plan to take a  
13 look at some of that work, and because it does help to put a  
14 better sort of face on those measures, I am hopeful we will  
15 be able to get something out of that that will let us turn  
16 that presentation around a little bit and go in the  
17 direction you are talking about.

18 MR. CHERNEW: I'm supportive of recommendation one  
19 and sympathetic to recommendations two and three, but I  
20 still have one concern, and it is basically in the line of  
21 what Bill said. I think I can describe it as recommendation  
22 two is potentially, depending on how the word reflect is

1 interpreted, really strong; and recommendation three, which  
2 I am supportive of, is somewhat weak in the sense that it  
3 requires there to be a study and an assessment to develop  
4 methods. So there is going to be potentially some window of  
5 time where there has been, if our recommendations were  
6 followed, a big cut in payment while we are still trying to  
7 figure out how to adequately protect quality, the language  
8 that is in three.

9           The reason I am worried is not knowing a ton about  
10 this area, if you have a bunch of efficient providers  
11 appropriately paid and a bunch of new gaming providers come  
12 in, you will see the margins rise. And if one decides then  
13 to cut the margins in one way or another to reflect the  
14 average cost where you are averaging across the gamers and  
15 the non-gamers, the ones that exit aren't the ones that  
16 entered. You end up having a situation where the bad drive  
17 out the good, because it might be the only -- and I don't  
18 know this to be the case, but you could have a situation  
19 where the only way you could survive in this industry with  
20 this payment rate is to be a gamer because you have used the  
21 gaming numbers that average to drive down payment rates.

22           And so I am not sure that is going to happen, and

1 I believe that directionally we are going in the right way,  
2 but I am not sure that recommendation three, which I believe  
3 is our make sure we do no harm kind of recommendation, is  
4 strong enough to really make sure we do no harm, if it ended  
5 up that all the good providers were actually the ones that  
6 are in the 3 percent and they are the ones that are doing  
7 the visits and they are the ones that haven't upcoded and  
8 they are the ones that are doing all those things.

9           So I just don't know enough about the production  
10 function to know how this is going to work.

11           MR. HACKBARTH: Would you put up number three for  
12 a second, Evan? Recommendation three.

13           I agree with your general characterization of  
14 three, but I actually look at three as having two parts, one  
15 that may be easier than the other. I may be wrong on this,  
16 but it seems to me to develop a payment system that  
17 attenuates the gains at the high end of the profit  
18 distribution and mitigates the losses at the low end is a  
19 relatively easy thing that could be done as part of the  
20 rebasing process; whereas, the quality indicator thing I  
21 think is potentially more challenging and may take a little  
22 bit more time.

1           Based on Bill's earlier comment, you know, what I  
2 would think would be very important in the text is to  
3 emphasize the link between rebasing and the attenuation of  
4 profits and losses, the mixed payment system, and then urge  
5 as fast action as possible on the quality indicator piece of  
6 it.

7           MR. CHERNEW: My concern was that if you took this  
8 the way that I read it, which is it is basically a study of  
9 ways to do these things, and I was concerned that when we  
10 get to 2011 and we do this big rebasing, that we study it  
11 right now. And depending on the speed and the separateness,  
12 you could end up in a situation where your more optimistic  
13 vision of the way it all plays out, which I would be very  
14 support of, isn't the vision that actually plays out.

15           MR. HACKBARTH: What I would propose is, rather  
16 than try to capture these ideas in the boldface language of  
17 the recommendation, that we have some very clear language in  
18 the text that talks about the link between rebasing and  
19 adjustments in the payment system, to make sure it doesn't  
20 come across as, well, rebase now and when you get a chance,  
21 to do this recommendation three stuff.

22           MR. CHERNEW: [off microphone] The problem is the

1 heterogeneity is captured in the rebasing.

2 MR. HACKBARTH: Does that make sense to people?

3 Do people feel comfortable with that?

4 Okay. Nancy?

5 DR. KANE: I guess I am less concerned about the  
6 terrible inequities of rebasing in that the base year that  
7 was used, which was 1997, I believe, reflected a different  
8 patient population. It was before -- what was it? I forget  
9 which one. Maybe it was the Balanced Budget Act -- came in  
10 and really eliminated eligibility for the benefit for a lot  
11 of the less needy, to a whole set of patients.

12 So we really are looking at different populations  
13 of patients, so I don't know that this is the gaming problem  
14 or the fact that the old system was based on people who were  
15 much more of the long-term custodial people who just became  
16 ineligible after, I think, 1997 or 1998 when the BBA kicked  
17 in. There was a huge, there was a million-beneficiary drop,  
18 and then a change in who came back in.

19 So I am not so nervous about the rebasing being  
20 sort of even hitting gamers versus non-gamers as it is  
21 getting more reflective of who the actual new beneficiary  
22 mix is after BBA changed it.

1 DR. SCANLON: I guess I am very concerned about  
2 that. I think --

3 DR. KANE: Before you interrupt, let me just go  
4 one more step. I guess the other piece on two, if we could  
5 go back to two, which is the one I was addressing, and to go  
6 back to Peter's comment about average cost, one of the  
7 things that does concern me about home health and cost is my  
8 sense is their capital requirements are like next to  
9 nothing, other than working capital; whereas, if you look at  
10 a SNF, at least they have a facility. And so, you know,  
11 what do they need a whole lot of profit for? is one of my  
12 questions. No doubt it is to subsidize their Medicaid and  
13 perhaps some of their other uncompensated care pieces. But,  
14 you know, I don't think we need to get too obsessed with  
15 maintaining a huge profit margin in that their capital  
16 requirements are nothing like some of the other types of  
17 silos that we set rates for that have much lower profit  
18 margins, like hospitals, for instance.

19 So I guess I am just kind of not too -- you know,  
20 I guess I feel like worrying about the profit margin of a  
21 low capital intensity industry is just not as much of a  
22 concern to me as it might be in a higher capital requirement

1 industry, a silo.

2 MR. BUTLER: Just to clarify, that wasn't my  
3 point. It was their non-Medicare business and what that  
4 looks like. You have got to at least be a break-even  
5 overall, or sooner or later you are going to go out of  
6 business. I don't think that they need another level of  
7 profit to invest. They don't have the same capital needs,  
8 you are correct.

9 DR. KANE: But, again, Medicare is -- I mean, we  
10 have as a principle that we shouldn't be setting rates to  
11 help us subsidize other payers. I guess I am just less  
12 concerned about that.

13 DR. REISCHAUER: We are trying to ensure access to  
14 a set of services, not the institutions that are providing  
15 it now. And there doesn't seem to be any problem about sort  
16 of institutions coming into this area.

17 DR. SCANLON: I guess my concern is that if you  
18 take recommendation two and you were to rebase solely on the  
19 basis of total costs, and the current margin is averaging 15  
20 percent, you are going to take this distribution and you are  
21 going to reduce the payments by 15 percent. That is going  
22 to take the agency that is providing care and earning a 4-



1 or a 5 percent margin into negative territory. It is going  
2 to take the agency that is making 40 percent today, and they  
3 are going to make 25 percent tomorrow. That doesn't seem to  
4 me to be a good use of public funds to preserve a system  
5 where an agency is making 25 percent. And how they are  
6 making 25 percent? The concern in this situation is that  
7 they are making 25 percent not by being more efficient, just  
8 by not visiting the people in their homes.

9 DR. KANE: Well, I think what you are saying is  
10 don't just use whatever people -- don't use the average  
11 cost, but try to look at why the costs are different.

12 DR. SCANLON: But, see, recommendation two  
13 involves making a rebasing decision in the current  
14 structure; whereas, recommendation three says let's change  
15 the structure of the reimbursement. And so you don't  
16 accomplish what we want in terms of redistributing the money  
17 unless you go to recommendation three.

18 And I agree with Glenn. You can do a version of  
19 recommendation three with respect to the corridors and  
20 everything very, very quickly. All you have to do -- I  
21 mean, the structure is easy to lay out. You have to come to  
22 some agreement on what the parameters are going to be, and

1 there is both sort of policy and sort of political decisions  
2 that go on there. But it is, you know, technically very,  
3 very feasible.

4 We went from passing the Balanced Budget Act in  
5 1997 to the Interim Payment System in 1998, so, you know,  
6 you can make changes, I think, of this magnitude in a  
7 relatively short amount of time.

8 MR. HACKBARTH: So, Bill, what I have suggested is  
9 that that link that you have been talking about is, in fact,  
10 important and that we highlight it in the text. Are you  
11 satisfied with that approach? If not, what would your  
12 alternative be?

13 DR. SCANLON: My only alternative would be to say  
14 that we go to three immediately, I mean, as opposed to doing  
15 two, because I think that we want -- and I would moderate  
16 two from where Peter was. Rebasing to me is that you  
17 decide, okay, here is what the pie is and how we are going  
18 to cut it up. And the pie in the past has been sort of  
19 budget neutrality. Well, we don't want to do that because  
20 it is 15 percent profit build into a budget-neutral pie. We  
21 don't necessarily need to go to a zero profit pie. We could  
22 go to a 5 percent average pie and divide that up as

1 rebasing.

2           So there are variations of this that are less  
3 problematic, but the most ideal is to go to three, but I  
4 understand how radical it is.

5           MR. HACKBARTH: Let me just pursue this for a  
6 second. When you say do three right away, you are talking  
7 about the blended payment system part of three.

8           DR. SCANLON: Right.

9           MR. HACKBARTH: One way to do this -- and, again,  
10 my preference is just to try to capture all this in the  
11 text. But one way to do it would be to say concurrent with  
12 rebasing, do the blended payment thing, and then have number  
13 three be also develop quality indicators.

14           DR. SCANLON: Yes, three in my mind involves  
15 implicit rebasing because basically when you set those  
16 parameters to do blending, what you are going to be doing is  
17 you are going to be having targets in terms of what the  
18 overall pie is supposed to be.

19           MR. HACKBARTH: Reactions to that? Take the  
20 blended part of part three and move it into two.

21           MR. CHERNEW: I like this discussion. I think in  
22 some ways, Bill, you are looking at three the way I look at

1 my kids, which is it is kind of better than it is. By that  
2 I mean three is now a recommendation about study; it is not  
3 a recommendation about rebasing or changing payment rates or  
4 doing anything. The idea of blending three and two so you  
5 do them sort of simultaneously is more -- when you speak,  
6 you speak as if it is kind of blended, that you are both  
7 rebasing and changing payment forms simultaneously. That is  
8 the way you talk about what it is. But if you read what it  
9 is, that is not what it is. And that could be done -- I am  
10 fine with that being in the text.

11 MR. HACKBARTH: I am really worried about the  
12 time, so let me ask Evan and Mark whether they see some  
13 problem with taking what I've referred to as the blended  
14 payment part of three and move it into two, so two would  
15 say, in essence, concurrent with rebasing, do the blended  
16 payment; and then three would be work to develop the quality  
17 indicators. Is there a problem with that approach, Evan and  
18 Mark?

19 MR. CHRISTMAN: I don't see anything conceptually  
20 wrong with it. I think you could do those.

21 DR. MARK MILLER: The reason that I am more of the  
22 mind to try and be clear that we would like two and three to

1 occur concurrently but not say do a blended payment as part  
2 of two is we haven't, either as a Commission or as a staff,  
3 kind of thought through, well, what do we mean, we are  
4 blending there. And I understand in some of your  
5 articulation of this, I think in your mind you have a sense  
6 of how you would do it. I think you would go at it on the  
7 basis of profit. I don't think there has been a widespread  
8 discussion here among ourselves or among the staff.

9           What I am, however, comfortable with is to say we  
10 are really looking for a rebased payment in 2011 and a more  
11 intelligent payment system to deal with some of the problems  
12 that people have talked about here, whether it is gaming or  
13 concern about a certain type of patient not being treated,  
14 which in some ways are the same thing.

15           MR. HACKBARTH: The practical question that needs  
16 to be answered is: Well, what if developing the blended  
17 payment system with the quality indicators takes longer? Is  
18 MedPAC's position that the rebasing ought to wait until  
19 those pieces are ready to go concurrently? That is the  
20 question I would ask.

21           DR. KANE: Couldn't we also suggest that they  
22 rebase but implement it, you know, over a three-year period?

1 I mean, I thought by blending you meant blending what we are  
2 paying now with what we think we should be paying based on  
3 the actual cost and that you are blending that kind of, you  
4 know -- what do you mean by blending? Because, to me, you  
5 could say rebase and implement it over a three-year period.

6 DR. SCANLON: What we are talking about in  
7 blending is either what Newhouse has called the partial  
8 capitation model, what I call sort of risk sharing. I mean,  
9 it is the issue that we would set kind of a norm for profit,  
10 and then people would be allowed to make somewhat more than  
11 that, but once they went beyond that excessively, then we  
12 would reduce it. And we would also have some protections on  
13 the downside. It is the same thing that we have been doing  
14 in Part D in terms of risk sharing.

15 So why I am confident that this can be done is  
16 that we have done it in D, we have done it sort of in the  
17 Medicaid programs in all kinds of instances, where we say we  
18 are going to give you money, but we are also going to look  
19 at your costs, and we are going to have kind of -- well, to  
20 get to their profits, you have got to look at their costs,  
21 right? I mean, we're looking at sort of the difference  
22 between the money we paid them and their costs. I mean,

1 that is the profit measure.

2 MR. HACKBARTH: I feel like we are spinning our  
3 wheels a bit here, and we need to move on. What I propose  
4 we do is leave the recommendation language as is, but make  
5 it crystal clear in the text that what we envision is that  
6 the rebasing and the blended payment happen concurrently.

7 DR. SCANLON: And that the quality measurement  
8 development can be later than that.

9 MR. HACKBARTH: Right. Okay. We don't need to  
10 repeat it. I am with Bill. I don't think it is necessarily  
11 all that complicated to do. Okay. So that is the approach  
12 to this.

13 I have lost track of whether we were on round two  
14 or round one. I think we are ready to vote. Is there  
15 anybody who is not ready to vote yet?

16 Okay. On recommendation one, all of those opposed  
17 to recommendation one, please raise their hands? All of  
18 those in favor of one? Abstentions? Was that a delayed --  
19 okay.

20 Recommendation two, all those opposed to number  
21 two? All in favor of number two? Abstentions?

22 And number three, all opposed to number three? In

1 favor? Abstentions?

2 Okay. Thank you, Evan.

3 Next is inpatient rehab facilities. Go ahead,  
4 Kim.

5 MS. NEUMAN: Next, we're going to look at  
6 inpatient rehabilitation facilities, or IRFs. I am going to  
7 briefly recap some of the data on IRFs that we presented in  
8 December and provide some additional information in response  
9 to some of your questions. Then we'll have the Chairman's  
10 draft recommendation for your consideration.

11 First, though, I'd like to thank Hannah Neprash  
12 for her work on this presentation.

13 The first slide provides a couple of key  
14 background points on IRFs. The Medicare fee-for-service  
15 program spent \$6 billion on IRFs in 2007 with  
16 fee-for-service beneficiaries accounting for over 60 percent  
17 of IRF patients.

18 The 75 percent rule has been one of the most  
19 significant factors influencing IRF services in recent  
20 years, so I'm going to recap it briefly. As you will  
21 recall, historically, 75 percent of a facility's patients  
22 were required to have certain specific diagnoses in order



1 for the facility to be paid as a IRF. After CMS discovered  
2 that many IRFs were not in compliance with the rule, they  
3 made some changes to the rule beginning in 2004. They  
4 limited the types of hip and knee-replacement patients that  
5 would count toward the rule. They also renewed enforcement  
6 of the rule beginning in 2004 with a phase-in of the  
7 compliance percentage from 50 percent to 75 percent over  
8 several years.

9           Before the phase-in was completed in December of  
10 2007, the Medicare, Medicaid, and SCHIP Extension Act of  
11 2007, or MMSEA, permanently capped the threshold at 60  
12 percent retroactive to July 1, 2007, going forward. For  
13 ease of reference, I will continue to refer to this rule as  
14 the 75 percent rule in this presentation, since for most of  
15 the analysis period, IRFs were under the impression that the  
16 threshold would eventually reach 75 percent.

17           Next, we will take a quick look at the available  
18 data on IRFs. First, supply of facilities. The first line  
19 in the chart shows that the number of IRFs increased  
20 modestly between 2002 and 2005 in the initial years of the  
21 PPS and has decreased modestly since then with the renewed  
22 enforcement of the 75 percent rule. We see a fairly similar

1 trend in the number of IRF beds, with a modest increase in  
2 the total number of beds from 2002 to 2004, and then a  
3 modest decrease from 2004 to 2007.

4           The decrease in the number of IRF beds since 2004  
5 has been less than the decrease in the number of discharges,  
6 suggesting that capacity remains adequate to meet demand.  
7 In fact, between 2004 and 2007, the aggregate IRF occupancy  
8 rate has declined from 67 percent to 61 percent.

9           In the December meeting, Jennie and Glenn, you  
10 both asked about the geographic distribution of IRFs. This  
11 slide shows the location of IRFs throughout the United  
12 States. In 2007, every State had a least one IRF. There  
13 were more IRFs in some areas of the country than others,  
14 however. There tend to be more IRFs in the Eastern and  
15 South Central portions of the United States.

16           The next slide shows the number of IRF beds per  
17 100,000 Medicare beneficiaries, which provides a measure of  
18 IRF capacity relative to the size of a State's Medicare  
19 population. Most States had between 51 to 110 IRF beds per  
20 100,000 Medicare beneficiaries. The States with the two  
21 darkest shades on the map had more beds than this, while the  
22 States with the lightest shade had fewer.

1           Next, volume and payment. After an increase in  
2 fee-for-service volume in the early years of the PPS, volume  
3 has decreased since 2004 with renewed enforcement of the 75  
4 percent rule. Some of the decline in Medicare  
5 fee-for-service volume is the result of increasing Medicare  
6 managed-care enrollment.

7           Controlling for the change in the fee-for-service  
8 population, the top line of the table shows an average  
9 decline in Medicare fee-for-service volume of about 7.5  
10 percent per year between 2004 and 2007. The decrease in  
11 volume has slowed in 2007. Volume declined on average 9  
12 percent per year from 2004 to 2006, and 5 percent from 2006  
13 to 2007.

14           While volume declined, Medicare payments per case  
15 increased as IRFs treated fewer hip and knee replacement  
16 patients who tend to be less complex and have lower  
17 reimbursement.

18           This next chart shows you the shift in the mix of  
19 patients that's occurred. Hip and knee replacement cases,  
20 which were the most common IRF cases in 2004, have declined  
21 substantially, falling to the third most common type of case  
22 in 2008. Stroke has become the most common IRF case and

1 fractures of the lower extremity or hip fracture have become  
2 the second most common.

3 To understand what the decline in fee-for-service  
4 IRF cases has meant in terms of access to care, we've looked  
5 at hospital discharge patterns to post-acute care settings  
6 for hip and knee replacement patients as well as other  
7 conditions frequently admitted to IRFs.

8 What we've seen with regard to hip and knee  
9 replacement patients is that as the share of hospital  
10 patients discharged to IRFs has declined, we've seen a  
11 corresponding increase in discharges to home health and  
12 SNFs. This data suggests that hip and knee replacement  
13 patients previously treated in IRFs are receiving care in  
14 other settings. It does not, however, tell us whether  
15 outcomes have been affected by the shift in site of service.

16 On that front, CMS's post-acute care  
17 demonstration, which is fielding a common patient assessment  
18 instrument across post-acute care settings, may provide some  
19 insight. A CMS report to Congress on the demonstration is  
20 due in 2011.

21 Now, onto quality. As you will recall, to measure  
22 quality, we look at an indicator commonly tracked by the

1 industry, the functional independence measure. We look at  
2 the functional independence gain, or the FIM gain, between  
3 admission and discharge to measure quality. From 2004 to  
4 2008, we see an increase in FIM gain, suggesting  
5 improvements in quality. However, these data are not  
6 risk-adjusted for changes in patient mix, so we have to be  
7 cautious in interpreting them.

8           Moving next to capital, as mentioned in previous  
9 presentations, access to capital has tightened in 2008 due  
10 to economy-wide issues in the credit markets. These changes  
11 in the credit markets are broad and not related to specific  
12 changes in Medicare payment policy. Nonetheless, economy-  
13 wide issues in the credit markets may result in increased  
14 capital costs or delayed capital investments for IRFs.

15           Now, looking at payment and costs, they tracked  
16 each other closely prior to the PPS. Following  
17 implementation of the PPS, we initially saw payments grow  
18 faster than costs, but with implementation of the 75 percent  
19 rule in 2004, growth in costs per case accelerated as IRFs  
20 began to treat fewer patients with less complex conditions  
21 who did not meet the rule. Cost growth has slowed some in  
22 2007, suggesting that adjustments to the 75 percent rule are

1 leveling off.

2 In terms of margins, the aggregate Medicare margin  
3 increased substantially after implementation of the  
4 prospective payment system, reaching nearly 18 percent in  
5 2003. Medicare margins have declined modestly each year  
6 since then.

7 The aggregate Medicare margin in 2007 was 11.7  
8 percent. Margins vary by type of provider. For example,  
9 freestanding and for-profit IRFs have particularly strong  
10 Medicare margins, 18.5 percent and 17 percent, respectively.  
11 Nonprofit and hospital-based IRFs have lower but still  
12 favorable aggregate Medicare margins of around 8 to 9  
13 percent.

14 Peter, you asked why hospital-based IRFs have  
15 lower margins than freestanding IRFs. Economies of scale  
16 appear to be one factor at work. Hospital-based IRFs have,  
17 on average, a smaller number of discharges and lower  
18 occupancy rates than freestanding IRFs. If we look at  
19 margins by size of facility, we see that margins are higher  
20 for larger facilities than smaller facilities, suggesting  
21 economies of scale is at least a partial explanation.

22 The aggregate Medicare margin for 2009 is

1 projected to be 4.5 percent. This represents a decrease  
2 from the estimated 2007 margin of 11.7 percent. The  
3 projected decrease is due almost entirely to the zero update  
4 for the last half of 2008 and full year 2009 enacted by  
5 MMSEA. It is important to note that these margin  
6 projections do not assume any increased cost control efforts  
7 by IRFs in response to MMSEA's negative updates or the  
8 recent declines in volume. To the extent that IRFs restrain  
9 their cost growth in response to these changes, the  
10 projected 2009 margin would be higher than we have  
11 estimated.

12 To summarize, facilities and beds declined  
13 modestly in 2007. Volume and spending declined, as well,  
14 while payments per case increased. Access to care appears  
15 to be adequate, but is complicated to assess. In terms of  
16 quality, there has been an increase in functional gain over  
17 time that case-mix changes prevent definitive conclusions.  
18 The 2009 projected margin is again 4.5 percent.

19 So with that, we have the draft recommendation for  
20 your consideration. It reads: The update to the payment  
21 rates for inpatient rehabilitation facilities should be  
22 eliminated for fiscal year 2010.

1           The implications are a decrease in spending  
2 relative to current law, estimated to be between \$50 million  
3 and \$250 million in one year and less than \$1 billion over  
4 five years.

5           In terms of beneficiaries and providers, there may  
6 be increased financial pressure on some providers, but  
7 overall, we would expect a minimal effect on providers'  
8 willingness and ability to care for Medicare beneficiaries.

9           With that, I will conclude our presentation and  
10 look forward to your discussion.

11           MR. HACKBARTH: Clarifying questions for Kim?

12           DR. STUART: It may just be me, but I found it  
13 confusing to think of the 75 percent rule as a 60 percent  
14 rule. I can understand why you did it, but because the 75  
15 percent rule was never actually implemented -- well, it was  
16 for about six months, but then it was undone. So when I get  
17 near the end of the chapter and I see the 75 percent rule, I  
18 just have to say 60 percent.

19           And then I'm beginning to think, well, maybe it  
20 should have been 75 percent. And so part of my question is  
21 semantic. But the other part is what would have happened  
22 had this rule actually fully been implemented?



1 MS. NEUMAN: Well, I think if it had been fully  
2 implemented, there would have been continued shifts in the  
3 type of patients treated by IRFs, as we've seen in some of  
4 the data. I think there would have been a continuation of  
5 that.

6 In as far as what is the right number, I think  
7 that that is an open question. One of the things that MMSEA  
8 did was require that CMS do a report to Congress--it's due  
9 this summer -- where they'll look at the impacts of the 75  
10 percent rule and consider whether they are alternatives to  
11 it. So that is a venture that is going forward.

12 MR. HACKBARTH: Isn't the tricky part of answering  
13 Bruce's question what institutions do in terms of adapting  
14 to this presumably smaller volume? If you went to the 75  
15 percent rule, they would be focused more on a smaller group  
16 of patients. So the question becomes how quickly do they  
17 adjust their staffing and other fixed and semi-fixed costs  
18 in response to the new market that they face. That's sort  
19 of the tough thing to predict.

20 MS. NEUMAN: Right. There's definitely questions  
21 about how quickly they can adjust their cost structures and  
22 adapt to the changes in the patient mix.

1           As we saw in these shifts of patients, what has  
2 happened largely is not that they're taking more stroke  
3 patients, it's that they're taking less of the patients that  
4 don't meet the 75 percent rule. It's sort of adapting to  
5 that new dynamic in their cost structure.

6           DR. CHERNEW: What do we know about the quality of  
7 care in IRFs versus quality of care for comparable patients  
8 outside of IRFs, and the quality of care for non-qualifying  
9 patients in and outside of IRFs? In other words, we talk  
10 about -- we always do this by providers, but I'm just  
11 curious as to if you didn't go there, where would you go,  
12 how would it be, how would your care be?

13           MS. NEUMAN: That's a big question that's still  
14 open to research. There's a number of --

15           DR. CHERNEW: [off microphone] It's something I  
16 want to know but [inaudible].

17           MR. HACKBARTH: It is sort of the \$64 million --  
18 billion -- question in post-acute care and work is underway  
19 to try to get better answers to it. That's the short  
20 answer.

21           MR. GEORGE MILLER: Just a clarification. On the  
22 slide 15, do you have the breakdown of the range by

1 percentile of the not-for-profits and for-profits like you  
2 did for all IRFs up at the top? What's the variation in the  
3 25th to the 75th?

4 MS. NEUMAN: You want that for for-profit versus  
5 not-for-profits?

6 MR. GEORGE MILLER: Yes, just like you did up  
7 above.

8 MS. NEUMAN: Yes, I do have that. For the  
9 nonprofits, the 25th percentile is a minus six, and the 75th  
10 percentile is 18. For the for-profits, it's the 25th  
11 percentile is minus three and the 75th is 22.

12 MR. GEORGE MILLER: Thank you.

13 DR. KANE: On page 10, do we have a sense -- this  
14 is the distribution of total hip and knee replacement when  
15 they stop going to -- when fewer go to IRFs and more go  
16 to--do we have a sense of what the payment change is between  
17 2004 and 2007 as a result of the number shifting from IRF to  
18 SNF and home health, because I think that would sort of help  
19 us think about whether it's a good thing or a bad thing to  
20 have this redistribution.

21 MS. NEUMAN: We do not have an estimate at this  
22 point of the cost differences.

1 DR. KANE: Payment. I mean payment, the Medicare  
2 payment.

3 MS. NEUMAN: There's sort of a twofold answer to  
4 that. There's just the difference in payments to IRFs  
5 versus the difference in payments to SNF, assuming they go  
6 nowhere else. And then on top of that, there's the question  
7 of where do they go next for post-acute care and does that  
8 differ depending on which setting they started in and how  
9 does their whole sort of series of payments look like?  
10 Unfortunately, the short answer is that we don't have a  
11 definitive cost estimate right now, but it's something that  
12 we've thought about looking at.

13 DR. REISCHAUER: You could do this with an episode  
14 grouper, right?

15 MS. NEUMAN: Yes, you could consider an episode  
16 grouper.

17 MR. LISK: Yes. I mean, what you do see  
18 generally, in general patterns for the hip and knees is the  
19 SNF -- the stay in the SNF is longer than it is in the IRF.  
20 Both frequently end up using home health afterwards. The  
21 readmission rates back to hospitals end up being slightly  
22 higher in SNFs, being a little bit higher in SNFs than in

1 IRFs, although that is in general on average, but we'd have  
2 to control better for the differences in the patient mix to  
3 really definitively get at that. So that's the general  
4 thing. It's complicated.

5 MR. HACKBARTH: Any other round one clarifying  
6 questions? How about round two comments, any?

7 DR. KANE: Just to kind of comment on the answer  
8 to my question, it seems that that's fairly important to  
9 know. I mean, that's the whole point of having a 75 percent  
10 rule, I assume, is that the assumption is some of these  
11 patients shouldn't be going to IRFs and there's a reason.  
12 That seems like low-hanging fruit, using the episode type of  
13 methodology to just say, is it at least less or more  
14 expensive, and then the other issue is does it take longer.  
15 And then a third issue is, is it a better or lower  
16 functional outcome.

17 If we can't get at the third one, it doesn't mean  
18 we shouldn't answer the first two, and I think we have the  
19 data to do that if we -- I think it would be really helpful  
20 for me to know going forward, should we continue to support  
21 the 60 percent or whatever rule or should we say it had the  
22 wrong effect and we should drop it?

1 DR. CASTELLANOS: Just listening to your comment  
2 about remission rates, I guess as it applies to slide 10,  
3 you said there's less remission rates with the IRFs, is that  
4 what you said?

5 MR. LISK: In general, it's a little bit less than  
6 SNF, but there's differences in the patient population. The  
7 population that generally goes to the SNF has been  
8 historically a little bit older and stuff, so therefore also  
9 more likely to be readmitted. Some other --

10 DR. CASTELLANOS: Is there a stinting problem or  
11 is that a 60 percent problem or is that a what problem?

12 MR. LISK: It could be a combination of things.  
13 You have to remember, an IRF is a hospital, so certain  
14 complications they might be able to treat that a SNF is not  
15 capable of treating, so therefore you may have higher  
16 readmissions under the circumstances.

17 MR. HACKBARTH: Yes, I would think that that would  
18 be at least part of it. You've got greater capabilities in  
19 the IRF that allow you to avoid some readmissions that  
20 others could not.

21 MR. LISK: I mean, there are cases where SNFs do  
22 not necessarily have RNs 24 hours and where the IRF would

1 licensed have to, in certain patients, certain  
2 circumstances, might require 24-hour nursing in certain  
3 circumstances. So that would be one reason.

4 DR. CASTELLANOS: Isn't it true with IRFs that you  
5 do have some risk-assigned patients there, over 85,  
6 bilateral hips, and body mass? So doesn't that take  
7 something out of that?

8 MR. HACKBARTH: Even for those, they're required  
9 to go to IRFs, but there are exceptions in the 75 percent  
10 rule, right. Kim, did you have something on that?

11 MS. NEUMAN: No.

12 MR. HACKBARTH: Okay. Other round two comments?

13 MS. HANSEN: Again, I think maybe to your point,  
14 Ron, is just who the patient profile is makes such a big  
15 difference in terms of the use of the resources. And it is  
16 on complexity and cognition, as well, too, because I think  
17 sometimes that is kind of one of those third-rail factors  
18 that oftentimes I don't how one measures. But frankly,  
19 having worked with the population for 25 years, I just know  
20 that that will vary oftentimes the kind of setting and  
21 resources that you do. So the grouping then has to be  
22 looked at more carefully, but again, that's kind of the big

1 question as to what that appropriate profile is.

2           So I don't know, whatever work we can do with some  
3 of the quality folks and looking at the risk adjustor-type  
4 profile, that seems to be an important factor as to whether  
5 or not you can go to a home health agency. Or if you're a  
6 60-year-old person who is fairly healthy with no cognitive  
7 issues, going to something that's quick and with no likely  
8 readmission versus somebody who's got multiple conditions  
9 and is very forgetful about treatments, the readmission risk  
10 is going to be higher.

11           So I don't know how one captures that, but then  
12 you can, I think, do the dollar episode comparison as a  
13 result. But it should hopefully be more apples to apples  
14 then.

15           MS. NEUMAN: Just to comment on that, that is sort  
16 of one of the challenges in the research that has been done  
17 in this area, trying to compare costs across the settings,  
18 is are the patients in the different settings comparable and  
19 you can you ever control for that accurately or adequately?

20           DR. MARK MILLER: Even with the episode stuff,  
21 which was back over here, I don't know that these  
22 adjustments always kind of rise to it. We found some really



1 interesting things between hospital-based SNFs where there's  
2 this assumption of much more complex and more intense  
3 patients, but when you got underneath some of the case-mix  
4 adjustment and looked at the patient, they actually tended  
5 to be younger. They had family to support them. They were  
6 assessed to be likely to recover faster. And so there were  
7 some really intense selection issues that were occurring,  
8 coupled with the notion that we're talking about what's  
9 really a hospital. So the remission kind of gets blunted  
10 because we're already in a hospital setting.

11           The other thing I'll say about this is at this  
12 time -- this is now dated, of course, but at the time of the  
13 60 or 75 -- Bruce, now you've really got me all screwed up -  
14 - at the time of the 75 percent rule, dammit, and it was a  
15 75 percent rule then, we were concerned about this. We got  
16 a physician consultant and put a bunch of physicians on the  
17 phone who did this type of thing and had this discussion  
18 about these types of patients, hips and knees, and what's  
19 going to happen, and had that kind of conversation. There  
20 was a lot on the phone of the world is falling apart, you've  
21 got to put these patients in. It was interesting, because  
22 there was one physician on the phone who said, actually, I

1 live in--and I can remember where--and we don't have these.  
2 I have designed for hip and knee replacements an entire  
3 program that revolves around the home health setting. You  
4 do exercise before. And he said a bunch of other things  
5 that I'm not able to reproduce here. He said, I don't use  
6 these at all and I'm willing to say to anybody on the phone  
7 that my patients' outcomes are as good as anyone else's.

8 It's kind of a complicated area. In addition to  
9 the risk adjustment, it's very hard to get at these things.

10 MS. HANSEN: And I actually would concur with his  
11 experience. Even in our PACE program, sometimes we have  
12 found people, even with cognitive problems, being in the  
13 hospital environment, whether it's IRF-like, it's iatrogenic  
14 and it creates more secondary problems. So bringing them  
15 out to a more normalized setting, say a home health --  
16 they're in a home setting, the recovery rate was incredibly  
17 fast. So these are, again, clinical applications, but not  
18 easily measured research-wise.

19 MR. HACKBARTH: Any others? Ready to vote? Would  
20 you put the recommendations up on the screen, Kim?

21 So all opposed to the proposed recommendation,  
22 please raise your hand? All in favor? Abstentions?

1           Okay, thank you. Good work.

2           And last is long-term care hospitals.

3           MS. KELLEY: Good afternoon. Today I'm going to  
4 answer some questions asked last month about RTI's recent  
5 analysis of LTCH use, and then we'll review our findings on  
6 payment adequacy for LTCH services, and then you'll discuss  
7 the Chairman's draft recommendation.

8           So, first let me address some questions that Bruce  
9 and John asked last month. You both asked about how use of  
10 services in Medicare payments for medically complex patients  
11 differed in areas with LTCHs compared with areas without.  
12 As we discussed in December, this is something MedPAC looked  
13 at a few years back, using 2001 data.

14           You'll recall that, after the Commission  
15 recommended the development of patient and facility criteria  
16 for LTCHs in 2004, CMS contracted with RTI to study the  
17 issue. RTI analyzed LTCH, acute care hospital, and  
18 post-acute care claims data from 2004. So, this is more  
19 recent than the work that we did. And I'll review some of  
20 the major findings from RTI's analysis.

21           RTI found two important factors that predicted  
22 LTCH admission. The first was severity of illness. Having

1 an APR-DRG severity score of four more than doubled the  
2 probability of an LTCH admission relative to having a  
3 severity level of two.

4 A second strong predictor of LTCH admission was  
5 whether the beneficiary lived in a state where many LTCHs  
6 were available. Patients in high LTCH states such as  
7 Louisiana, Massachusetts Indiana, Michigan, Pennsylvania,  
8 Ohio, Texas, they were almost three times more likely to be  
9 discharged to a LTCH, and these findings were consistent  
10 with MedPAC's earlier findings.

11 RTI also found that, all else equal, having an  
12 LTCH admission was associated with a shorter acute care  
13 hospital stay by about one-and-a-half days, suggesting that  
14 LTCH care may be substituting for some of the later days of  
15 an acute care hospital stay. Again, our earlier analysis  
16 observed the same phenomenon.

17 RTI also looked at LTCH's per-case margins and  
18 found that they varied substantially across DRGs, even after  
19 stratifying to remove the effects of high-cost outlier  
20 payments and short-stay outlier payments. This variation in  
21 profitability stemmed from bias in the DRG weights which caused  
22 systematic understatement of cost for cases using relatively

1 more ancillary services.

2           And so, then, getting specifically to the  
3 questions that were asked, RTI look at areas with LTCHs to  
4 examine differences in costs and outcomes between ventilator  
5 patients who were transferred to LTCHs and those who  
6 remained in acute care settings. The analysis focused on  
7 these patients because a diagnosis of tracheostomy with at  
8 least 96 hours of acute care ventilator support is the  
9 strongest clinical predictor of LTCH views.

10           RTI's findings may suggest that went less complex  
11 patients are transferred to LTCH's, they have higher  
12 Medicare payments per episode and similar or worse outcomes  
13 than clinically similar patients in the same area who do not  
14 use LTCH services. But the most complex patients appear to  
15 have better outcomes in the LTCH and the same or lower per  
16 episode payments. So, complexity really matters. Although  
17 there are some limitations to this type of analysis, the  
18 findings tend to support those of the Commission.

19           Finally, RTI matched four market areas with LTCH's  
20 to four without to determine if there were area-level  
21 differences in episode outcomes among clinically similar  
22 ventilator patients. This analysis found that LTCH supply

1 may be associated with fewer days per episode for ventilator  
2 patients, but there appear to be no impact on Part A cost  
3 per episode, and there also appeared to be no impact on  
4 rates of mortality or readmissions.

5           The results of the study led RTI to make several  
6 recommendations for identifying appropriate LTCH cases and  
7 payment levels, some of which are listed here. I won't go  
8 to them item by item, but will just point out that some of  
9 RTI's recommendations echoed those the Commission made  
10 earlier, specifically the recommendation to require LTCH  
11 admissions to have certain medically complex conditions, and  
12 the recommendation to establish specific facility criteria  
13 as conditions of participation.

14           Finally, RTI argued that one of the major issues  
15 at hand is whether LTCH and short-term acute care hospital  
16 payments are appropriate for medically complex patients  
17 needing intensive treatment programs. As a result, RTI  
18 recommended that CMS conduct additional research to examine  
19 the adequacy of payments for these patients under both the  
20 LTCH and the acute care hospital PPSs.

21           In addition, RTI raised conditions that both  
22 hospitals, both short-term acute care hospitals and LTCH's,

1 might be unbundling services for which they've already been  
2 paid and discharging patients to the next level of care, and  
3 RTI recommended that more research be done on this as well.

4           And it's not up here on the slide, but I have one  
5 more question to address. George, you asked how many  
6 hospitals within hospitals are owned by other companies  
7 rather than the hospital they are located in. Slightly more  
8 than half of all LTCHs are hospitals within hospitals and,  
9 by our estimate, about half of hospitals within hospitals  
10 are owned by other companies, notably Select Medical  
11 Corporation.

12           So, now, let's turn to our review payment  
13 adequacy. I'll summarize the results of our analysis of  
14 supply, access and volume, quality, access to capital, and  
15 payments and costs.

16           First, we found, as you can see here, that supply  
17 has stabilized after a period of rapid growth.

18           This slide shows that growth in the number of LTCH  
19 cases per fee-for-service beneficiary has been fairly  
20 stable, suggesting that access has been maintained. It's  
21 not shown here, but growth in payments per case has slowed  
22 markedly but remains positive, while length of stay

1 continues to decline.

2           Turning to quality: last month we presented our  
3 finding that readmission rates and rates of death were  
4 stable or declining for most of the top 15 LTCH diagnoses;  
5 This was a good finding. This month we also looked at four  
6 hospital-level patient safety indicators developed by AHRQ,  
7 decubitus ulcers, infection due to medical care,  
8 postoperative pulmonary embolism, or deep vein thrombosis,  
9 and postoperative sepsis. We found that there were fewer  
10 cases of infection due to medical care and postoperative  
11 sepsis in 2007 compare with 2006. At the same time,  
12 however, there was a small increase in the number of cases  
13 with decubitus ulcers and postoperative PE or DVT. As  
14 always, we're cautious about relying on the results from our  
15 analysis of patient safety indicators, as these indicators  
16 were developed for acute care hospitals, not LTCHs.

17           We found that access to capital varies across the  
18 industry but generally has tightened across the board.  
19 This, of course, reflects economy-wide issues rather than  
20 Medicare payment adequacy. At any rate, you will recall  
21 that the Medicare, Medicaid and SCHIP Expansion Act of 2007  
22 placed a three-year moratorium on LTCH growth, so the need



1 for capital may be limited.

2 Overall, the 2007 margin was 4.7 percent. Our  
3 predicted margin for 2009 is 0.5 percent. This is because,  
4 in the absence of behavior changes, we expect that cost  
5 growth in 2008 and 2009 will outpace payment growth despite  
6 some payment relief included in MMSEA.

7 Moving onto the draft recommendation you discussed  
8 last month. It reads as follows: The Secretary should  
9 update payment rates for long-term care hospitals for Fiscal  
10 Year 2010 by the projected rate of increase in the  
11 rehabilitation, psychiatric, and long-term care hospital  
12 market basket market, less the Commission's adjustment for  
13 productivity growth. Under current market basket  
14 assumptions, this recommendation would update the LTCH  
15 payment rates by 1.6 percent.

16 The Secretary has discretion to update payment  
17 rates, but CMS has stated its intention to use the market  
18 basket as a starting point for establishing updates to LTCH  
19 payments. Thus, a recommendation of market basket minus  
20 productivity will produce savings relative to a market  
21 basket. This update is not expected to affect providers'  
22 willingness and ability to care for Medicare beneficiaries.

1           So, I'll be happy to answer any questions you  
2 might have.

3           MR. HACKBARTH: Round one clarifying questions for  
4 Dana?

5           MR. GEORGE MILLER: Just briefly -- first of all,  
6 thank you for answering the questions. And I wrote the  
7 numbers down, but I guess I'd like to draw the analogy to  
8 the question about the percentages of hospitals within a  
9 hospital. If I remember the numbers you gave, there did not  
10 seem to be a correlation with ownership of the hospital with  
11 the -- the parent company with the hospital. Do I have that  
12 correct, that most of the hospitals within hospitals are  
13 owned by someone else?

14           MS. KELLEY: About half of the hospitals within  
15 hospitals are owned by someone else.

16           MR. GEORGE MILLER: About half? Okay. Thank you.

17           MR. HACKBARTH: Other clarifying questions? How  
18 about round two comments?

19           DR. KANE: Just to be consistent with my other  
20 comments about home health and some of the other ones, I  
21 know we've suggested that there should be some kind of way  
22 to assess function and all of that. It's just very

1 frustrating to not know anything about the difference in  
2 costs or outcome of who goes for an LTCH versus who doesn't.

3 Is there anyway, again, to use the episode grouper  
4 to come up with common diagnoses for LTCH's, ventilator  
5 dependent people, and just see what the differences in  
6 outcome and cost are when they go to LTCH versus the many  
7 people who are probably not in LTCH market areas and what  
8 their cost differences are?

9 I just feel that we do have some data and we don't  
10 seem to be using it, and I understand the differences and  
11 difficulties of adjusting, but I don't get a sense of what  
12 the value added and I really think we need to have a better  
13 handle on that, of an LTCH versus just an acute care say.

14 MS. KELLEY: I do think we have some information  
15 about how costs differ, the outcomes based on the work that  
16 RTI did and that the Commission did earlier. What we don't  
17 have is good outcome and quality data.

18 DR. KANE: So what are the cost differences?

19 MS. KELLEY: Well, precisely.

20 MR. GEORGE MILLER: To follow up on Nancy's  
21 comments, does not AHRQ or the Joint Commission have quality  
22 standards for these?

1 MS. KELLEY: Long-term care hospitals have to meet  
2 the same requirements that acute care hospitals meet. They  
3 are certified as acute care hospitals.

4 MR. GEORGE MILLER: So, those quality measures,  
5 are they not applicable here? Did you say that you were  
6 hesitant to use MedPAC's quality data?

7 MS. KELLEY: No, we used AHRQ's patient safety  
8 indicators, but they were developed for acute care  
9 hospitals.

10 MR. GEORGE MILLER: Okay. I see. Oh, that was  
11 the correlation?

12 MS. KELLEY: Yes.

13 MR. GEORGE MILLER: Okay. Thank you.

14 DR. REISCHAUER: You said half of the hospitals  
15 within hospitals are owned by somebody else. Are these  
16 chains that own them for-profit chains?

17 MS. KELLEY: Yes.

18 DR. REISCHAUER: So, they would have them in  
19 various other hospitals?

20 MS. KELLEY: Yes.

21 DR. MARK MILLER: Just to Nancy's point, if I  
22 understood the exchange, and I've been missing a lot of

1 balls today, so, I'm going to -- a few years ago, when we  
2 did this analysis, we did look at the difference in cost  
3 between beneficiaries who use this as part of their episode,  
4 versus use LTCH's, versus others. We found, just to your --  
5 and again, with lots of caveats on knowing the outcomes and  
6 all of the rest of it, that's what led us to our conclusion  
7 that if you're into the severity level three and four types  
8 of patients, this made more sense for patients like that to  
9 go there, but at the lower levels, not. And that's similar,  
10 or the same, or thereabouts, to what RTI has just come up  
11 with.

12 MS. KELLEY: Yes, that complexity really matters  
13 and that costs really equalize with the very high severity  
14 patients. But I think the main caveat would be that the  
15 only control for outcomes in quality that we have -- the  
16 only way we were able to look at outcomes was using  
17 readmissions a mortality rate. We don't have anything more  
18 specific than that. I assume that you're talking about  
19 something a little more detailed.

20 DR. KANE: Yes, kind of the overall episode.

21 But also, if they were to only do these higher  
22 complexity patients, what would that do to their occupancy

1 and their ability to cover their fixed costs? I guess it's  
2 like the IRFs. We just drove their occupancy down from 67  
3 to 61 percent, and these are high fixed-cost businesses.  
4 So, I'm just curious to know a little bit more about what  
5 the range of --

6 DR. MARK MILLER: If I could pick up there. So,  
7 for the last several years, our sets of recommendations of  
8 focusing it on the high acuity patients have been discussed  
9 in great detail in the industry and CMS, and the industry  
10 agrees that to focus should be on the high complexity  
11 patients.

12 Also, you will remember -- and you, too, because  
13 I'm pretty sure you were here when some of this discussion  
14 when on, and this is one thing that we want to look at.  
15 Nick used to argue that, because of what you just said, we  
16 -- as a policy, may want to start thinking of these as  
17 referral. It may not be that you want -- some of the  
18 frustration with these things is, when they were growing,  
19 they were growing in the same marketplaces. For what you're  
20 pointing to -- is this may be a very select population. And  
21 so, some of the policy questions we been asking ourselves in  
22 thinking about going down this road is, should we start

1 thinking of these as referral areas for precisely the reason  
2 that you're saying, because there should be a relatively  
3 small segment of the population? Sorry.

4 DR. BORMAN: Just to follow up on what Mark just  
5 brought up, my own experience with this relates mostly to an  
6 area where the access to tertiary care is somewhat more  
7 constricted.

8 In order to allow those resources to be utilized  
9 most effectively, the LTCH was often the vent, if you will,  
10 from the acute care hospital, and primarily for  
11 ventilator-dependent patients.

12 And I heard some of the presentation correctly --  
13 and it was a very nice presentation -- defined as I could  
14 follow it, a lot of this does indeed circle around the  
15 ventilator-dependent patient. And they are almost by  
16 definition going to be in that high severity, whatever,  
17 level group. So, maybe there is a natural experiment  
18 comparison here since there is this geographic focus of LTCH  
19 that we -- an analysis limited to just that group, that is,  
20 the failure-to-wean group perhaps winnowed down by a couple  
21 of diagnoses on a geographic basis. Obviously, you have to  
22 control for some of the wage and some of the other economic

1 geographic variation, might be somewhat informative in terms  
2 of believable outcome comparison for those two groups by  
3 defining it fairly slickly in that way.

4 MR. HACKBARTH: Other round two comments? I think  
5 we're ready to vote then.

6 All opposed to the recommendation, please raise  
7 your hand? All in favor? Abstentions?

8 Thank you, well done.

9 We will conclude with a public comment period.

10 Seeing none, we are adjourned until 9:00 a.m.  
11 tomorrow.

12 [Whereupon, at 4:30 p.m., the meeting was  
13 recessed, to reconvene at 9:00 a.m. on Friday, January 9,  
14 2009.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 9, 2009  
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair  
JACK C. EBELER, M.P.A., Vice Chair  
MITRA BEHROOZI, J.D.  
JOHN M. BERTKO, F.S.A., M.A.A.A.  
PETER W. BUTLER, M.H.S.A  
RONALD D. CASTELLANOS, M.D.  
MICHAEL CHERNEW, Ph.D.  
FRANCIS J. CROSSON, M.D.  
THOMAS M. DEAN, M.D.  
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N  
NANCY M. KANE, D.B.A.  
GEORGE N. MILLER, JR., M.H.S.A.  
ROBERT D. REISCHAUER, Ph.D.  
WILLIAM J. SCANLON, Ph.D.  
BRUCE STUART, Ph.D.

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## 1 P R O C E E D I N G S

2 MR. HACKBARTH: We have two topics today, hospice  
3 and Medicare Advantage. And on the hospice issue we will be  
4 discussing and voting on recommendations.

5 Kim, are you leading or is Jim leading? Jim?

6 DR. MATHEWS: Good morning. Today we will be  
7 following up on information on Medicare's hospice benefit  
8 that we presented in November of last year. We have some  
9 additional qualitative and quantitative analyses for your  
10 consideration and some revised draft recommendations.

11 Before we begin, I wanted to highlight some of the  
12 more significant changes to the document that we've made in  
13 response to your comments at the November meeting.

14 Karen, who is not here today, asked for some  
15 additional context material and we've added this both to the  
16 introduction and at the conclusion of the chapter.

17 Nancy and Bill, you asked for more information on  
18 the basis for setting payment weights under the revised  
19 system. We've discussed this by phone in the interim, but  
20 to help you assess the impacts of one set of weights versus  
21 another, we've included the full impacts of the two sets of  
22 weights on pages 18 through 20 of the revised chapter.

1 We've also changed the date certain for implementation to  
2 reflect the need for additional data collection and  
3 evaluation.

4 Mike, you asked for more information on potential  
5 behavioral responses by providers under the new system, and  
6 we've added this to pages 20 through 23.

7 Jack, George and Peter, you asked for additional  
8 breakdowns of types of hospices with the number of  
9 beneficiaries who receive care in each type. We're still  
10 developing this data and they're not in the materials that  
11 you have at the moment, but they will be in the version that  
12 will really be released for review by the end of the day --  
13 hopefully by the end of the day.

14 We've also made some minor changes throughout the  
15 document in response to your discussion.

16 Lastly, I do want to remind everyone that Zach  
17 Gaumer also made significant contributions to the report.

18 Before we move on to the new substantive material,  
19 we went to briefly recap a couple of points about the  
20 hospice benefit that led us to where we find ourselves  
21 today. First, hospice provides an alternative form of care  
22 for beneficiaries who do not desire conventional

1 interventions at the end-of-life. In order to elect  
2 hospice, the beneficiary needs certification of likely death  
3 within six months. In electing hospice, beneficiaries  
4 forego curative treatment for their terminal condition but  
5 receive a wide range of services not covered by traditional  
6 Medicare with little cost-sharing.

7           Second, in addition to giving beneficiaries a  
8 choice about their end-of-life care, the hospice benefit was  
9 implemented with the expectation that hospice was less  
10 costly than conventional end-of-life treatment and would  
11 result in lower Medicare spending.

12           As we've discussed previously, Medicare's payment  
13 system contains an incentive for providers for long stays in  
14 hospice, rather than appropriate timing of admission. This  
15 incentive potentially undermines the statutory presumption  
16 that hospice would result in lower Medicare spending than  
17 conventional end-of-life care.

18           As indicated in your mailing materials, we see a  
19 number of parallel trends in hospice use. Length of stay is  
20 increasing but in a very uneven way. Average length of stay  
21 increased from 62 days in 2000 to 82 days in 2006. But at  
22 the 90th percentile of the distribution, the stays increased

1 from 144 days in 2000 to 212 days in 2005, an increase of  
2 almost 50 percent.

3 Stays at or below the median length of stay  
4 declined by a day during this time, so it is only the long  
5 hospice stays that are getting longer.

6 We demonstrated previously that there is a strong  
7 correlation between length of stay and profitability.  
8 Hospices with the longest stays on average have the highest  
9 Medicare margins. This may help explain why virtually all  
10 hospices newly participating in Medicare since 2000 have  
11 been for-profit enterprises.

12 Additionally, we believe that inadequate oversight  
13 may have contributed to these trends. CMS and its fiscal  
14 intermediaries have not had the resources to closely monitor  
15 trends or assess whether improper practices partly account  
16 for the patterns we've seen in the last several years.

17 Based on your prior direction and our subsequent  
18 analytic work, we developed draft recommendations in three  
19 areas which we presented in November. This work was further  
20 informed by input from individual hospices, hospice  
21 associations, and an expert panel we convened in October of  
22 last year.

1           First, we developed a direction for changing  
2 Medicare's hospice payment system, moving from a linear  
3 approach to an intensity adjusted approach, more consistent  
4 with hospices' efforts in caring for patients.

5           Second, we identified the need for more  
6 accountability in the hospice benefit and drafted a multi-  
7 part recommendation aimed at increasing accountability,  
8 which is detailed at length in your paper.

9           Lastly, we identified the need for more and better  
10 data with which Medicare could improve its management of the  
11 hospice benefit.

12           Today, first we will discuss the recommendation to  
13 change the payment system. As you will recall, Medicare's  
14 current payment system is generally linear. Medicare pays  
15 hospices a fixed amount for each day a patient is enrolled.  
16 The longer a patient is enrolled, the greater the hospice's  
17 Medicare revenues.

18           You'll recall, however, that hospices' costs  
19 follow a U-shaped curve. Hospices incur a higher cost  
20 associated with the increased level of effort at the  
21 admission of a patient to hospice and during the time  
22 surrounding the patient's death. The interim period is less

1 costly, reflecting the establishment of a routine of care.

2           Obviously, there are deviations from this pattern  
3 with respect any given patient that we might discuss, but in  
4 general this seems to be the general pattern.

5           This led us to recommend changing the hospice  
6 payment system in a way that more closely approximates  
7 hospices' costs during the course of an episode. Payments  
8 would be high in the early days of admission but would  
9 decline as the hospice stay got longer. Medicare would make  
10 an end of episode payment after the patient's death,  
11 reflecting the hospices' higher level of effort.

12           This structure would give hospices a greater  
13 incentive to screen potential patients to ensure they were  
14 admitted at the most appropriate time in the course of their  
15 terminal condition. It would also reinforce the notion that  
16 hospice is an end-of-life benefit rather than a long-term  
17 care benefit.

18           We had not yet completed our payment model in  
19 November but since then have developed two alternate sets of  
20 payment weights that follow the U-shaped curve. To keep  
21 this discussion clear, we will only talk through one  
22 example, portrayed on the screen, but you have a full



1 discussion of both in your paper. Together, they provide  
2 examples of how the impacts of the payment system change  
3 vary depending on the degree of the intensity adjustment.  
4 These weights now include the end of episode payment that  
5 would be made upon the patient's death, which we discussed  
6 but which we had not yet modeled when we presented the  
7 material in November.

8           The weights, as you see here, are higher in the  
9 early part of the episode. It's at this point, surrounding  
10 the patient's admission, that the hospice devotes a  
11 significant amount of effort. Activities include developing  
12 the plan of care, assessing medical and medication needs,  
13 introducing the patient and family members to the hospice  
14 team, and generally establishing a protocol of  
15 communications.

16           As the hospice episode continues, the patient's  
17 care settles into a routine with visits provided by the  
18 interdisciplinary team per the plan of care. Obviously,  
19 acute incidents can occur during this time, which may  
20 require disruptions from the standard routine home care.

21           Lastly, the weights increase at the end of the  
22 episode, associated with the higher level of effort by the

1 hospice surrounding the patient's death. In addition to  
2 palliative and patient care, these activities include  
3 pastoral and other counseling, and family counseling that  
4 can extend beyond the death of the patient.

5           There are a few other points that we went to  
6 emphasize in describing our payment system changes. First,  
7 our model deals with home care only and presumes that  
8 payments for inpatient care what continue as under the  
9 current system.

10           Second, payments are still made on a per diem  
11 basis but in contrast to the current system these payments  
12 would decrease as length of stay increases.

13           Third, payments under the new system would be  
14 budget neutral to payments under the old system in the first  
15 year.

16           Lastly, as shown graphically in the previous  
17 slide, the level of the end of episode payment made at the  
18 time of the patient's death would be at the same high rate  
19 as the payments made at the beginning of the episode.

20           The impacts of the new payment system relative to  
21 the current one would vary as a function of length of stay.  
22 Here we have shown the impacts by the share of a hospices'

1 caseload represented by patients whose stays exceed 180  
2 days, broken into quintiles. We've shown the impacts of  
3 both the larger intensity adjustment that we showed on the  
4 chart a couple of slides ago, along with the smaller  
5 adjustment discussed in your paper.

6           Hospices with the lowest share of patients whose  
7 stays exceed 180 days would see their payments increase by  
8 24 percent relative to the current system under the larger  
9 intensity adjustment. The effect on payments would decline  
10 along the length of stay continuum. Hospices with the  
11 highest shares of patients whose stays exceed 180 days would  
12 see their payments decline by almost 11 percent under the  
13 new system relative to what they are getting now. Payments  
14 under the weights reflecting the smaller intensity  
15 adjustment follow a similar pattern but with less pronounced  
16 changes.

17           The main point though -- and we will say this  
18 again before the end of the presentation -- is that the  
19 payment impacts vary as a function of length of stay.

20           Here you see the impacts of going to the new  
21 system as reflected in some of our standard provider  
22 categories. Geographically, urban hospices would see a

1 slight decrease in payments in either system, while payments  
2 to rural hospices would increase by between 2.2 and 2.8  
3 percent, depending on the set of weights used.

4           Payments to provider-based hospices, which have  
5 the shortest average length of stay, would increase by  
6 almost 11 percent using the larger intensity adjustment and  
7 by almost 8 percent using the smaller adjustment.

8           Payments to for-profit and freestanding hospices  
9 would decline relative to the current system because these  
10 providers have longer stays on average than nonprofit and  
11 provider-based hospices. Payments to nonprofit hospices  
12 would increase by between 2.5 and 4.1 percent under the  
13 weights we have modeled here.

14           Within these categories, however, the new system's  
15 impact will vary considerably, again as a function of length  
16 of stay. For example, while half of for-profit hospices  
17 would see their payments reduced by more than 2 percent  
18 under the new system, 40 percent would see their payments  
19 increase by more than 2 percent. The reductions or  
20 increases within each category vary as a function of length  
21 of stay. So here, for-profit hospices with shorter stays  
22 will actually gain under the new system. Because their

1 lengths of stay tend to be lower, any more provider-based,  
2 nonprofit, and rural hospices would see their payments  
3 increase than would have their payments decline under the  
4 system we've modeled here.

5           As we stated in November, there are several  
6 benefits to the intensity adjusted payment approach. First,  
7 it reinforces hospice as an end-of-life benefit and  
8 incorporates incentives to ensure that hospice provides the  
9 optimal balance of benefits to Medicare beneficiaries and  
10 the program itself.

11           By incorporating higher payments at the beginning  
12 and end of the hospice episode, the revised system ensures  
13 that hospices have sufficient resources to deliver care at  
14 these particularly important junctures. It also better  
15 matches hospices' actual cost curve in the course of an  
16 episode and includes payment adjustments to make hospices  
17 more sensitive to the impacts of long stays.

18           We project that the revised system will reduce the  
19 number of hospices exceeding Medicare's payment cap. Under  
20 the two sets of weights projected here, the number of  
21 hospices exceeding the cap would decline by 26 percent under  
22 the smaller adjustment and by 45 percent under the larger

1 intensity adjustment.

2           Additionally, the new system provides higher  
3 reimbursement for patients with very short stays in hospice,  
4 which in the aggregate are unprofitable for hospices under  
5 the current system. As a result, this payment system  
6 revision may provide an incentive for hospices to take  
7 greater efforts to appropriately lengthen stays for what are  
8 currently very short stay patients.

9           It's worth emphasizing at this point that there is  
10 reasonably broad support for this recommendation across the  
11 industry in principle and as a general direction. There is  
12 some concern regarding the specific point estimates, what  
13 the payments should be during each part of the episode and  
14 how long each part should be. Some of you have expressed  
15 similar concerns.

16           On this note, what we are recommending is the  
17 direction that CMS should go in reforming the hospice  
18 payment system, not the specific point estimates. We've  
19 also modified the recommendation itself to give CMS  
20 additional time to collect and evaluate data to reform the  
21 payment system along the lines of what we are recommending.

22           Remember also the MedPAC will likely have ample

1 opportunity to provide additional analyses to help inform  
2 CMS's efforts and would, of course, have the opportunity to  
3 review the final system.

4           So now we'll move to the recommendation. Note  
5 that the recommendation has changed somewhat since you last  
6 saw it, clarifying some aspects of the new payment proposed  
7 system and adding a date certain for the new system to be  
8 implemented, as I just mentioned.

9           The recommendation reads: the Congress should  
10 direct the Secretary to change the Medicare payment system  
11 for hospice to: increase payments per day at the beginning  
12 of the episode and reduce payments per day as the length of  
13 the episode increases; include a payment system for the  
14 higher costs associated with patient death at the end of  
15 episode; implement the payment system changes in 2013 with a  
16 brief transitional period.

17           These payment system changes should be implemented  
18 in a budget neutral manner.

19           We now have a CBO score for this recommendation,  
20 which we didn't have in November. Because it would be  
21 implemented in a budget neutral manner, there are no impacts  
22 on spending in the first year. Over five years, providers'

1 behavioral changes in response to the incentives in the new  
2 system will result in relatively small savings.

3           We do not anticipate that the payment system  
4 change will adversely affect beneficiaries' access to  
5 hospice care. We expect that there will be fewer very long  
6 hospice stays as hospices pay closer attention to the timing  
7 of hospice admissions. At the same time it is possible that  
8 what are currently very short stays may become longer under  
9 the new system.

10           The effects of the payment system change on  
11 hospices will vary as a function of their share of stays  
12 over 180 days. To the extent that hospices with a large  
13 share of such patients are small and do not have a patient  
14 base that allows them to manage the risk of some patients  
15 incurring very long stays, they will likely have to increase  
16 their patient census or merge with other hospices in order  
17 to remain viable under the new system.

18           With that, I'll turn it over to Kim for the rest  
19 of the presentation.

20           DR. MARK MILLER: Can I just say one quick thing,  
21 just before we shift over to the accountability? I know you  
22 were just being really precise on the scoring. The



1 negligible savings over the five years, we are talking about  
2 \$100 million on like a \$10-plus billion base or something  
3 like that?

4 DR. MATHEWS: That is correct.

5 DR. MARK MILLER: We're talking about -- just in  
6 the interest of being clear about what CBO said -- but we're  
7 talking about dust in the end here.

8 MS. NEUMAN: We will now move on to our next  
9 recommendation. Last month we also presented information  
10 that led us to develop a two part draft recommendation on  
11 the need for greater accountability in the hospice benefit.

12 As we stated in November and earlier in this  
13 presentation, long hospice stays are getting longer while  
14 short stays remain largely unchanged. There is substantial  
15 variation across hospices in terms of the amount of long  
16 stay cases they have. The 20 percent of hospices with the  
17 most long stay cases have on average 34 percent of their  
18 hospice stays exceeding 180 days compared to an average of  
19 14 percent among all other hospices.

20 We've also seen that there is a subset of hospices  
21 that rely very heavily on nursing home patients and these  
22 hospices tend to have longer stays and are more likely to be

1 for profit.

2           It is important to note there are inherent  
3 uncertainties in predicting life expectancy and it is  
4 natural that hospices will have some long stay patients.  
5 However, the increase in very long hospice stays and the  
6 variability across providers in the amount of long stay cases  
7 is a concern because information we have gathered suggests  
8 that it may be driven in part by financial considerations or  
9 other factors not related to the patient's condition.

10           As you'll recall, in October of last year we  
11 convened an expert panel of eight hospice medical directors  
12 and hospice administrators. Panelists came from both  
13 for-profit and not-for-profit hospices and from a wide range  
14 of geographic areas. A medical director from a Medicare  
15 claims processing contractor also participated. Discussions  
16 with the expert panel suggested two potential explanations  
17 for the trends we currently observe in long stays.

18           First, some hospices could be responding to the  
19 profit incentives for long stays in the current payment  
20 system. Such hospices may choose to interpret Medicare  
21 coverage guidelines in such a way as to liberally admit  
22 patients of questionable eligibility, especially patients

1 likely to have long stays. The correlation between length  
2 of stay and profitability, the entry almost exclusively of  
3 for-profit hospices, and the specialization of some hospices  
4 on nursing home patients reinforces this hypothesis.

5           Furthermore, several expert panel members provided  
6 examples of questionable enrollment practices among some  
7 providers in their communities such as, at the extreme, some  
8 hospices reportedly prohibiting physicians from visiting  
9 patients for recertification purposes, never discharging  
10 patients for improved prognosis, enrolling patients who had  
11 been turned away by other hospices, disregarding the  
12 Medicare eligibility guidelines, aggressively marketing to  
13 individuals likely to have long stays as such as nursing  
14 home patients, or marketing hospice without mentioning the  
15 terminal illness criteria.

16           Second, some members of the expert panel believe  
17 that some hospice staff, both the medical directors,  
18 physicians and clinical staff, may be insufficiently trained  
19 in palliative medicine to adequately apply CMS's coverage  
20 guidelines to specific patient circumstances. In this case,  
21 insufficient engagement of the hospice medical director may  
22 also be a contributing factor.

1           Which brings us to draft recommendation 2(a),  
2    which describes additional controls that should be put in  
3    place to help ensure that Medicare's policies encourage  
4    hospices to admit patients at a point in their terminal  
5    disease trajectory that provides the most benefit for the  
6    patient. The measures in this recommendation are targeted  
7    to increase accountability and oversight most on hospices  
8    with the longest stays.

9           This is generally the same recommendation you saw  
10   in November with the exception of the third bullet.  
11   Previously it focused on long stays at hospices with an  
12   average length of stay of greater than 120 days. We've  
13   changed it to direct the attention on hospices with a large  
14   share of patients whose stays exceed 180 days. This change  
15   better focuses attention on those hospices that have a large  
16   share of patients whose stays exceed the six-month  
17   presumptive eligibility period.

18           The draft recommendation now reads: the Congress  
19   should direct the Secretary to: require that a hospice  
20   physician or advanced practice nurse visit the patient to  
21   determine continued eligibility prior to the 180th day  
22   recertification and each subsequent recertification, and

1 attest that such visits took place; require that  
2 certifications and recertifications include a brief  
3 narrative describing the clinical basis for the patient's  
4 prognosis; and require that all stays in excess of 180 days  
5 be reviewed by the applicable medical director of the  
6 Medicare claims processing contractor for hospices for which  
7 stays exceeding 180 days make up 40 percent or more of their  
8 total cases.

9           The supporting narrative also indicates that the  
10 Congress should provide CMS with the resources necessary to  
11 enforce existing policies applicable to the hospice benefit  
12 and any new policies adopted on the basis of the  
13 recommendations herein.

14           Just one other note on this recommendation. Just  
15 to be clear with regard to the third bullet, as written it  
16 would only apply to the fiscal intermediaries and the  
17 Medicare administrative contractors. So if you wanted other  
18 parts of CMS to be doing the reviews of these claims, we  
19 would need more generic language there.

20           Again, we now have a CBO score for this  
21 recommendation. CBO estimates that it will have a very  
22 small effect on Medicare hospice spending.

1           There are a couple of potential effects on  
2 beneficiaries. First, beneficiaries who are currently  
3 receiving hospice care even though their symptoms do not  
4 meet the applicable guidelines are likely to see the timing  
5 of their admission to hospice change and be admitted to  
6 hospice later in the progression of their disease. Second,  
7 the greater physician engagement in the beneficiaries'  
8 hospice care could result in great quality of care.

9           The effects on hospices would vary again, as with  
10 our payment system recommendation, as a function of their  
11 share of patients with stays over 180 days. The additional  
12 medical review of claims would only affect providers with at  
13 least 40 percent or more of their cases exceeding 180 days.  
14 Also, providers with the most long stay patients would incur  
15 the greatest costs in providing physician visits as a part  
16 of recertifications for patients with stays exceeding 180  
17 days.

18           We anticipate there would be a modest impact on  
19 all hospice providers of including a narrative with each  
20 certification and recertification.

21           The second part of our accountability  
22 recommendation dealt with the need for OIG studies of the

1 intersection of Medicare's hospice benefit with nursing  
2 homes and other long-term care facilities. The draft  
3 recommendation has also changed slightly from the last time  
4 you saw it, with the addition of assisted living facilities  
5 in response to Bill's and Nancy's comments and the  
6 additional bullet on the appropriateness of enrollment  
7 practices among providers with unusual utilization patterns  
8 in response to Mitra's comments concerning program abuse.

9           Also, the final bullet has been broadened to  
10 include other admissions practices in addition to marketing  
11 materials and to examine their correlation with length of  
12 stay.

13           The draft recommendation now reads: the Secretary  
14 should direct the OIG to investigate the prevalence of  
15 financial relationships between hospices and long-term care  
16 facilities such as nursing facilities and assisted living  
17 facilities that may reflect a conflict of interest and  
18 influence admission to hospice. Differences in patterns of  
19 nursing home referrals to hospice, the appropriateness of  
20 enrollment practices for hospices with unusual utilization  
21 patterns -- for example, high frequencies of very long  
22 stays, very short stays, or enrollment of patients

1 discharged from other hospices -- and the appropriateness of  
2 hospice marketing materials and other admissions practices  
3 and potential correlations between length of stay and  
4 efficiencies in marketing or admissions practices.

5 The implications are the same as last time, with  
6 no impacts on Medicare spending. The OIG would be required  
7 to spend administrative resources on conducting these  
8 studies. The recommendation would have no immediate impacts  
9 on beneficiaries or providers.

10 We will now move on to our third draft  
11 recommendation, which deals with additional data needs. In  
12 November, we discussed the fact that the information  
13 currently collected via claims and cost reports is  
14 insufficient to fully understand the changes in hospice  
15 utilization that have occurred in the last several years.  
16 We presented two recommendations that outlined additional  
17 information that should be collected. For example, we  
18 indicated that claims should include information on the  
19 duration of visits provided and that cost reports should  
20 include both Medicare and non-Medicare revenue.

21 As a result of discussions with the Chairman since  
22 the November meeting, we have combined the prior separate



1 cost report and claims data recommendations into a single,  
2 more general, recommendation on the need for more data. The  
3 supporting narrative remains much as it was in November and  
4 outlines specific information CMS should collect via each of  
5 these two mechanisms.

6           The recommendation now reads: the Secretary should  
7 collect additional data on hospice care and improve the  
8 quality of all data collected to facilitate the management  
9 of the hospice benefit. Additional data could be collected  
10 from claims as a condition of payment and from hospice cost  
11 reports.

12           The implications of the recommendation are  
13 unchanged from last time. There are no direct spending  
14 implications but CMS and its intermediaries would be  
15 required to expend resources developing new cost reports,  
16 developing new claims fields, and developing corresponding  
17 provider education materials.

18           There would be no implications for Medicare  
19 beneficiaries, although the data could result in long-term  
20 refinements to the payment system that can help ensure  
21 equitable access for beneficiaries with all terminal  
22 conditions.

1           Providers would incur some additional costs as a  
2 result of this recommendation. These would include the  
3 costs of claims and cost report software, as well as  
4 training for staff on the new requirements.

5           To summarize, recent trends in hospice use suggest  
6 the need for reform of the benefit on the number of fronts,  
7 including payment system changes, the need for greater  
8 accountability, and the need for additional data to manage  
9 the benefit.

10           With that, we will conclude our presentation and  
11 we will be happy to answer any questions you may have.

12           MR. HACKBARTH: Nice job. In fact, nice job over  
13 a period of months on this project.

14           I had a couple of clarifying questions. In fact,  
15 I know Jack has one that is the same. Do you want to go  
16 ahead, Jack?

17           MR. EBELER: Jim, if you could go to the sixth  
18 slide, I just want to clarify for purposes of helping us  
19 understand the direction of these changes you've modeled  
20 these different percent weights and your subsequent analyses  
21 sort of show the direction of change with these weights and  
22 other weights. But as I understand, the recommendation

1     itself is not to use these weights but instead to direct the  
2     Secretary to come up with a stronger analysis to come up  
3     with the appropriate intensity weights. So these are  
4     examples, not recommendations, is that correct?

5             DR. MATHEWS: That is correct.

6             MR. EBELER: Okay. Thank you.

7             MR. HACKBARTH: Just to follow up on that same  
8     point, the policy goal, or one of the policy goals, is to  
9     change the payment system so that there is a reason to  
10    really focus on the admission decision, who is admitted to  
11    hospice, and make sure that they are appropriate in keeping  
12    with the purpose of the benefit. You change the weights to  
13    help achieve that goal.

14            Now, it seems to me that you only achieve that  
15    goal if for the long stays the payment level is below the  
16    marginal cost of delivering the care. So long as the  
17    payment is higher than the marginal cost, there's a reason  
18    to keep on delivering additional units of service, days of  
19    care in this case, is that right?

20            So what we're asking the Secretary to figure out  
21    is collect data that would allow them to make a reasonably  
22    good assessment of what that marginal cost is and that's an

1 important factor in the intensity weight for the long days,  
2 right? And so the data collection has to be done with an  
3 eye towards trying to approximate that figure, question  
4 mark?

5 DR. MARK MILLER: That's right, in concept.  
6 That's all correct. But I also think we should be -- and I  
7 need real engagement here from you two -- we also have to be  
8 careful that we're not overselling the precision that we're  
9 going to be having and able to do this. I think part of the  
10 reason the accountability things, or recommendations are in  
11 there, in particular looking at stays from hospices that  
12 consistently have long stays, are in part to also try and  
13 back in behind this, because the ability to extract data  
14 that says, this is precisely the right shape for this curve  
15 and here is the right marginal cost, I don't know that  
16 that's actually going to exist with that degree of  
17 precision.

18 The second comment on this that I would take you  
19 guys back to in your November discussion is there was also  
20 some discussion of, well, notionally you want a normative  
21 feel to this, that even if the data itself has a certain  
22 pattern, there may be an attempt with this payment system to

1 kind of shape the way care is provided during the episode,  
2 as well. So there's some --

3 MR. HACKBARTH: What I'm trying to get at is that  
4 I think I understand, at least in a broad sense, why it will  
5 be difficult to find that marginal cost figure with  
6 precision. But if you fail not to get the long stay  
7 payments low enough so that they're below that marginal  
8 cost, you may well not achieve in your policy goal, which is  
9 to affect the admission decision.

10 DR. REISCHAUER: Don't you want it below rather  
11 than equal to the marginal cost?

12 MR. HACKBARTH: Well, I'm out of my element here,  
13 as you well know, being a lawyer. But basically, what  
14 you're trying to do is get people to say providing  
15 additional units is not in my organizational interest. I  
16 want to think very carefully about that initial admission  
17 decision. So long as the payment is above the marginal  
18 cost, I'm not sure why they would think differently about  
19 the admission decision.

20 Now I'll shut up and let economists talk.

21 DR. SCANLON: Well, I mean, my sense was it's  
22 partly related to precision, but it's also an issue of sort

1 of how aggressive we are here, because I'm not sure --  
2 whether it's marginal costs or whether it is something  
3 between marginal and average costs that we really should be  
4 aiming at. I would worry that sort of in the seventh-plus  
5 month, that if you get the rate too low, I don't want  
6 stinting in that period, either. And so the situation now  
7 is horrible, I mean, in terms of the difference between the  
8 potential cost of care and the payment. You want to improve  
9 that, but I'm not sure you can get it to the point where  
10 it's -- you're exactly at the right level. And so you've  
11 got to balance it between this issue of don't encourage  
12 overutilization, but also sort of don't encourage stinting.  
13 Because again, we're sort of in a situation where we don't  
14 know what services are being provided.

15 DR. CROSSON: I think this question is a little  
16 bit derivative of the discussion that we just had and it  
17 requires referral to the figure two on page ten in the text,  
18 which was not in the presentation.

19 It has to do with, again, the topic of the  
20 relationship of the shape of the intensity adjustment to the  
21 impact on categories. This is sort of to set up a  
22 discussion perhaps later about whether or not this should be

1 budget neutral or not, or more aggressive than that.

2           So if you look at figure two on page ten, it shows  
3 the relationship between profitability and length of stay.  
4 If you take, for example, the 2006 numbers, it looks like --  
5 and I'm going to use quintiles because that's what is then  
6 used in figure eight in the presentation -- that the average  
7 margin -- and correct me here if I've made a mistake  
8 somewhere -- the average margin is about minus 3 percent.  
9 And for the quintile at the top, it's about 20 percent.

10           So I'm assuming these quintiles are roughly  
11 comparable to the quintiles that are then displayed in  
12 figure eight, although I can't tell because I'm not sure  
13 what the horizontal axis is in figure two. But if they're  
14 roughly comparable, it would suggest that if this particular  
15 intensity adjustment were applied, the net result -- and  
16 again, tell me if I'm wrong here -- would be to increase the  
17 profitability of the lower quintile to somewhere around 20  
18 percent and decrease the profitability of the highest  
19 quintile from about 20 percent to about 10 percent, which  
20 sounds a bit similar to what Glenn was suggesting in terms  
21 of whether this particular model fits with the goal. So I  
22 just wanted to see if that, in fact, is the case.

1 DR. MATHEWS: We have not actually connected these  
2 two graphics in the way that you're anticipating. Listening  
3 to you ask the question in the way that you have, I think  
4 there is some intuitive logic to the direction that you've  
5 laid out. The metrics for length of stay are slightly  
6 different between these two charts. On the one on the  
7 screen, we are measuring length of stay for this purpose as  
8 share of a hospice's patients who exceed 180 days. In  
9 figure two -- and you are correct, the legend is missing  
10 here -- the metric is the hospice average length of stay.  
11 So they are slightly different, but conceptually still get  
12 to the same place.

13 I would not want to definitively answer your  
14 question on the spot because I think there might be some  
15 patient weighting things that we would need to take into  
16 account, especially with respect to figure two, to make it  
17 exactly comparable to the chart here.

18 But yes, in general, this payment system change  
19 would increase the profitability of what are currently low  
20 length of stay hospices and decrease the profitability of  
21 hospices with very long lengths of stay.

22 MR. HACKBARTH: The trick here, it seems to me, is



1 that we're talking about a payment system that still is --  
2 it's not an episode-based payment system. It's still paying  
3 for additional units of service, additional days. Yet we  
4 have a policy goal which is sort of episode focused. We  
5 want to reduce the number of very long stays, but using a  
6 payment system that still pays more for each day.

7 Those two things, there's some tension between the  
8 payment method and the policy goal. And we're trying to  
9 resolve the conflict through pricing of the individual units  
10 and that is, I think, complex.

11 DR. CHERNEW: Do you mean episode in that  
12 sentence, like episode, hospice episode, or did you mean  
13 episode in that sentence like episode, end-of-life episode?

14 MR. HACKBARTH: I don't know. I was thinking  
15 hospice episode, but I am probably making a mistake by  
16 saying that. Why do you ask?

17 DR. CHERNEW: I was thinking end-of-life episode,  
18 but it sounded from your sentence like you were thinking  
19 hospice episode, and that --

20 MR. HACKBARTH: Yes.

21 DR. SCANLON: Kim, on recommendation two, you  
22 raised the issue for the third bullet about whether we would

1 want to modify it in terms of thinking of other parts of CMS  
2 or HHS. I guess the one that came to mind for me is the  
3 program integrity contractors. Was that where you were  
4 going, and do you think it's appropriate to expand it from  
5 both claims processing contractors to the program integrity  
6 contractors, as well?

7 MS. NEUMAN: The program integrity contractors,  
8 this is something that could be considered and they do do  
9 this type of review. So that is a potential option. There  
10 are other groups, as well, that sometimes do reviews, such  
11 as the RACs or the QIOs. Program integrity seems a natural,  
12 though, in the scheme of the other entities that are out  
13 there.

14 DR. CASTELLANOS: I think my questions are in part  
15 two, so I will wait.

16 DR. STUART: I'm fully in accord with the  
17 direction of these recommendations and I think you've done a  
18 great job in terms of laying out the issues for us.

19 I think we are all keenly aware of some of the  
20 issues at the margin in terms of how this is going to affect  
21 provider behavior. But one of the things that's not written  
22 here is that if we recommend that the provider payment

1 system be changed in 2013 and beyond, it means that we are  
2 still stuck with this thing for the next three years.

3 And so my question for the record is how are  
4 payment updates made currently for hospice, and then I have  
5 one follow-on question.

6 DR. MATHEWS: The hospice payments are updated  
7 annually by the inpatient hospital market basket.

8 DR. STUART: Okay. All right. And then the  
9 second --

10 DR. MARK MILLER: [off microphone] They are  
11 automatic.

12 DR. MATHEWS: That's correct.

13 DR. STUART: Right, because we have not made a  
14 recommendation about that. But implicitly, we're saying,  
15 okay, well, we're going to continue -- we recommend by not  
16 saying anything that we continue with this current system  
17 until the new system comes into place.

18 And then the second piece, by virtue of the fact  
19 that we're going to be maintaining this system for three  
20 years, even if the recommendation one is recommended, some  
21 of Kim's points certainly strongly suggest that there's some  
22 bad behavior out there. I agree with Jay in the sense that

1 if you've got bad behavior out there and we're struck with  
2 the current system for three years, that bad behavior that  
3 increases current spending is going to be incorporated in  
4 the payment base. So that question about budget neutrality  
5 for something that starts in the future is a concern, I  
6 guess.

7 DR. MARK MILLER: The one thing I would say about  
8 that -- and again, this is mostly a resource and timing  
9 issue. Next fall, and I realize your question could be, but  
10 why not now? We've been investing in trying to understand  
11 the area. Next fall, we anticipated once now everybody has  
12 a better understanding of hospice, we've made some  
13 recommendations to fix the underlying system, we can move to  
14 regular order of business on hospice and looking at updates.  
15 So I wouldn't assume that you're living with -- well, I  
16 mean, living with the underlying system for the next few  
17 years, but it doesn't necessarily mean that we are  
18 immediately saying all updates for the next three years are  
19 okay.

20 DR. MATHEWS: If I could make one more observation  
21 on that point, recommendation two, both A and B, are  
22 separable from the payment system recommendation and

1 arguably these could be implemented on a much quicker track  
2 than a payment system change.

3 MR. HACKBARTH: I assume the reason for the longer  
4 time period for the payment system reform is that we hope to  
5 use the additional data collection to inform the setting of  
6 the actual weights, is that correct?

7 DR. MATHEWS: That is correct, and waiting until  
8 2013 does give CMS a chance to get past the first year of  
9 data collection and start using data from years two and  
10 three, evaluate that, and promulgate a proposed rule.

11 DR. KANE: I have a second tier comment, but I  
12 guess my only first query question is what is an -- and I  
13 think it relates to what Mike was saying -- what do we mean  
14 by episode, because the benefit periods are 90-day  
15 increments. But what do we mean by -- I think we need a  
16 definition of episode in there. I think you mean from the  
17 minute you're admitted until death, but I don't think we  
18 have a common definition of episode yet.

19 Especially if you're trying to get past seven  
20 months and have that be -- when does month one begin and  
21 when does an episode end? What if they been discharged and  
22 reentered? Is it cumulative, because his grandmother went

1 in, what, two times and she's still living.

2 DR. MATHEWS: For purposes of this discussion, we  
3 been defining the episode loosely as the point of admission  
4 to hospice to the point that the patient is discharged or  
5 dies. If this system were to be implemented, CMS would have  
6 to deal with issues related to discharge live and subsequent  
7 readmission and how the payment would play out in those  
8 scenarios. Neither in this situation have we considered  
9 pre-hospice care as part of the end-of-life episodes. We  
10 are just dealing with what happens under the hospice  
11 benefit.

12 DR. CHERNEW: You mentioned the CBO scoring, and  
13 it's not surprising that it's a small effect because the  
14 recommendation says it should be implemented in a budget-  
15 neutral way. So it's pretty budget neutral.

16 My question was, did they make assumptions -- what  
17 assumptions did they make when they talked about behavioral  
18 changes that made it not exactly budget neutral? Was  
19 involved in changes in the use of the hospital or the  
20 nursing home or things like that, or was it just changes in  
21 length of stay?

22 And I have one more clarifying question about the

1 CBO calculations.

2 DR. MATHEWS: Yes. We've had very brief  
3 conversations with CBO on the rationale and one of the  
4 offsets that result that would -- one of the behavioral  
5 responses, or one of the factors that offset savings that  
6 would accrue under this proposal is the fact that delayed  
7 admission to hospice would presume continued use of other  
8 Medicare Part A and Part B services.

9 DR. CHERNEW: The last question I had about their  
10 scoring was did they take into account their baseline of the  
11 increased trend in length of stay, which is what I think  
12 would happen if we kept the current system, or did they not?  
13 In other words, this would reduce this trend we have had for  
14 greater length of stay, and so the savings relative to their  
15 baseline depend on if you think we keep the current system,  
16 that's going to keep going up. So it's budget neutral where  
17 we are now, but it's a big savings compared to where we  
18 would have otherwise been.

19 DR. MATHEWS: I do not know. We did not  
20 specifically discuss that point, but we can loop back.

21 DR. MARK MILLER: Actually, since they are working  
22 off of their current baseline, you know, they set a

1 baseline, they look at current trends, I think it's pretty  
2 safe to assume that they assumed some increase in lengths of  
3 stay, observing current data and projecting it forward.  
4 Precisely how much, we'd have to go back and ask.

5 DR. CHERNEW: But when we mean budget neutral,  
6 that's not what we mean. We don't mean implemented in a  
7 budget-neutral way that mimics those length of stay  
8 increases over time.

9 DR. MARK MILLER: Absolutely.

10 DR. CHERNEW: We mean budget neutral relative to  
11 where we are now. So a budget neutral thing relative to  
12 where we are now should be a big savings relative to their  
13 baseline, I would think. That's what I'm trying to clarify.

14 DR. MARK MILLER: There's a couple of things going  
15 on here. First of all, some of this conversation was also  
16 with Peter's question yesterday about the ASCs. When you go  
17 to a different payment system, you make an assumption about  
18 budget neutrality at the point where you are. We are making  
19 no attempt to pull money out as we reset the payment  
20 amounts. That's one budget neutrality concept. And so just  
21 to be clear, there's not an attempt to move money out at the  
22 point that you restructure the system.



1           The second point that we're making over the first  
2 year and the five-year point -- and this is really CBO  
3 making this point -- is that, well, on net, what happens to  
4 spending over that period? What they're saying is that  
5 there is a negligible -- which I can't say but apparently  
6 they can -- difference in the baseline.

7           I think part of what's going on is hospice  
8 expenditures will continue at some rate, and to the extent  
9 that a beneficiary doesn't go into hospice at the points  
10 that they currently are, some of that spending will be  
11 incurred on the acute care side. Is that --

12           DR. CHERNEW: I understand that that's possible.  
13 It is surprising to me, because I was under the impression  
14 that the growth in hospice spending was in part driven by  
15 this incentive to long length of stay. So I was under the  
16 impression that the trend in baseline was relatively high  
17 because of increasing length of stay. And I was under the  
18 impression that this recommendation, which I support,  
19 changes that incentive. So whatever --

20           DR. MARK MILLER: It's two things, though, Mike.  
21 People have been using the benefit a lot more and length of  
22 stay has been increasing.

1 DR. CHERNEW: It could work out that way. I just,  
2 in the things that I thought were important magnitude-wise  
3 in my mind, I was focusing on one relative to the other. So  
4 it might be that's true. I was trying to figure out if CBO  
5 -- how they were scoring the recommendation budget  
6 neutrality.

7 DR. MARK MILLER: And I'm giving you our best  
8 sense.

9 DR. CHERNEW: So I think I understand now.

10 DR. MARK MILLER: And on the very point about  
11 what's driving the expenditures of the length of stay versus  
12 the number of people, we kind of don't want to discourage  
13 the number of people.

14 DR. CHERNEW: [off microphone] I agree.

15 DR. REISCHAUER: Your definition of budget  
16 neutrality is based on a single year's spending, not on the  
17 next five years' spending.

18 DR. MARK MILLER: Absolutely, and so let me just  
19 restate this, and I'll do this very briefly because I know  
20 we're running out of time. It could very well have been,  
21 and in fact, we didn't know what to anticipate, that you  
22 build a budget-neutral system at year one and the behavioral

1 changes result in significantly less spending over five  
2 years, and not because the system tried to take money out  
3 but because of behavioral changes. What they are saying is  
4 that you're getting it in other places.

5 DR. CHERNEW: I'm going to forego my round two  
6 question and say, but the behavioral changes might not be  
7 behavioral changes relative to what we see now. They could  
8 be the absence of behavioral changes that we otherwise would  
9 have seen that are incorporated in the CBO baseline.

10 DR. REISCHAUER: They should be both.

11 MR. HACKBARTH: Mark, I'm a little concerned that  
12 the impression that we're leaving for the audience is that  
13 CBO has done a detailed budget estimate of this, and my  
14 understanding is that they have not. First of all, there's  
15 nothing for them to estimate. There's not a specific policy  
16 proposal. So in terms of actual weights and how they might  
17 affect behavior, and so would you just address what CBO has  
18 done here?

19 DR. MARK MILLER: As best as I can. Generally,  
20 what happens in our process to do these kinds of spending  
21 impacts is it's kind of a -- I wouldn't call it a full, and  
22 to your point, a full bore cost estimate that CBO does like

1 when they get a piece of legislation. Often what happens is  
2 we go through -- and we didn't do this so much here, but on  
3 the updates we will do a pass on the savings ourselves and  
4 then say to CBO, we think this generally falls in a set of  
5 buckets. Do you agree? And they say yes or no, and then we  
6 present the buckets.

7           Here, I don't know that we took a pass at this.  
8 We said our intention is budget neutral, told them the  
9 structure of the policy and gave it to them. They came back  
10 and said, this is what we think.

11           I don't know if there is any more precision you  
12 guys can bring to it.

13           DR. REISCHAUER: But the amount of behavioral  
14 change you are going to get is going to depend on the extent  
15 to which we have the intensity adjustment, you know, how  
16 deep the curve is. So there's no way for them to do it  
17 without very specific numbers. And if it's sort of a  
18 shallow curve, I can believe that there will be sort of  
19 offsetting effects and there won't be a whole lot. But  
20 otherwise, I think this chapter is basically an argument for  
21 why there should be rather substantial savings in hospice,  
22 and then you have to go to the literature on the extent to

1 which hospice for low-intensity kinds of people ends up  
2 saving or costing Medicare overall resources.

3 MR. HACKBARTH: It sort of sounds to me, Mark,  
4 like in a way, we gave the CBO the answer to the question  
5 when we asked the question. We said, this is a budget  
6 neutral change in payment policy, and they're saying, well,  
7 if it's budget neutral, then by definition there's not a big  
8 budget impact. And they really didn't have the wherewithal  
9 to look at complex behavioral responses to a new payment  
10 system.

11 DR. MARK MILLER: I'm trying to make eye contact  
12 with a couple of people here, and my sense is they did not  
13 proceed in that way and just say, okay, because you said, it  
14 is. They actually did look at what the potential behavioral  
15 effects of the policy was, is that right, Shinobu? Right.  
16 So it wasn't just a straight out, you said so, so we're  
17 taking it. We gave them some data. They did look at  
18 current baselines and they made some assumptions. Exactly  
19 what's behind that, I think is what we are not able to  
20 articulate.

21 MR. BUTLER: I understand, though, the most  
22 important thing is that you have -- are we going to do the

1 U-shape or not and how shallow or deep should it be is the  
2 heart of what we're advancing.

3 So my question more out of curiosity is that  
4 often, we are addressing issues in a somewhat similar  
5 fashion that Congress and CMS is doing on certain benefits.  
6 Is this one where we are out ahead of what is being  
7 considered by others? Or is something like this being  
8 considered already by CMS or Congress? Are we kind of like  
9 leading the way in this?

10 DR. MARK MILLER: I only heard the end of the  
11 question, but I think we are leading the way on this.  
12 However, since our discussions have occurred, we have been  
13 talking to CMS throughout this and CMS has said that they  
14 are very interested in these ideas. Kim? Is that correct?

15 MS. NEUMAN: Yes.

16 MR. BUTLER: I have one other quick follow-up  
17 question. We've talked a lot about financial disclosure in  
18 the past and make recommendations about collecting  
19 additional information and so forth. In this case, we are  
20 very specific about having the Secretary direct the OIG to  
21 do the leg work, which I understand is one way to do it. Is  
22 there any other flexibility in terms of who or how you would

1 address the conflict of interest issues, short of or  
2 different from the OIG?

3 DR. MARK MILLER: One thing on that point, and  
4 there was actual a little discussion between Bill and I this  
5 morning, is I anticipate that we will continue ourselves to  
6 look at the nursing home interaction, which is one of the  
7 conflict of interest issues, and that as we move forward and  
8 discuss this in the fall of next year, that in addition to  
9 whatever else we may want to say about hospice in general,  
10 we may have something more to say about that.

11 We ran through the data analysis which is reported  
12 in the chapter. It gets fairly complex about how to design  
13 a policy to deal with that, and so we just didn't feel like  
14 we were ready to go with a policy. But I would see us  
15 continuing to pay attention to this, at least.

16 MR. BUTLER: I just mention that because OIG at  
17 somebody's doorstep sets a different kind of tone in terms  
18 of collaboratively trying to figure out what's going on than  
19 maybe some other approaches.

20 MR. GEORGE MILLER: On draft recommendation two,  
21 I've got a clarifying question. It says they require that a  
22 hospice physician or advanced practice nurse. Now, is that

1 a palliative care physician boarded? Or is it an employee  
2 of a hospice program? And the same thing for nurse  
3 practitioner. Are you being specific on what the degree and  
4 the capability of that physician or any physician working  
5 for the hospice?

6 DR. MATHEWS: Here, we are defining this physician  
7 as the hospice medical director who has the responsibility  
8 for recertifying patients for hospice.

9 MR. GEORGE MILLER: The second part of that, as we  
10 try to deal with length of stay, would it make more sense or  
11 would it be something to consider moving the -- you say  
12 prior to the eligibility of the 180th day. Would it make  
13 sense to try to play that at the 90th day as being very  
14 prescriptive? And then maybe in addition to the 180th day,  
15 as a clarifying question?

16 DR. MATHEWS: Obviously, that's feasible, and when  
17 we've had discussions with some segments of the industry,  
18 some members have suggested that we could be indeed be even  
19 more --

20 MR. GEORGE MILLER: Prescriptive.

21 DR. MATHEWS: Yes, further up on the episode than  
22 we are here. So we are being very conservative in this



1 recommendation.

2 MR. GEORGE MILLER: But wouldn't we have a  
3 different impact if it was the 90th day, is my point I'm  
4 trying to address.

5 DR. MATHEWS: Yes.

6 MR. GEORGE MILLER: That would be more  
7 prescriptive?

8 DR. MATHEWS: That's correct.

9 MS. NEUMAN: And just to add to that, there are  
10 costs and benefits of shifting that time line. A lot more  
11 patients would be affected by the 90th day recertification  
12 than 180 days. So if you're trying to target resources,  
13 180-day targets you toward the patients who are moving  
14 beyond the presumptive eligibility period potentially.

15 MR. GEORGE MILLER: But I just want to reflect  
16 just -- I agree with Bruce, and I made the statement about  
17 home care. I'll make it here. Apparently, there are very  
18 bad actors and I'm struck by the relationship, and Peter  
19 mentioned it, with the nursing homes and the for-profit  
20 entities. I'm having problems with that and trying to  
21 reconcile all that in my mind. If we're going to do  
22 additional work, I'll just stop talking now and wait until

1 we get that additional work, but I'm concerned.

2 DR. MARK MILLER: This is probably obvious, but  
3 just to make sure that the public understands, the intent  
4 here was we think that there is a tail of a distribution  
5 here, in terms of both actors and -- in terms of actors who  
6 may be driving a lot of this. And so rather than have the  
7 accountability be very broad-based and in everybody's  
8 business, we are trying to target this to the tail of the  
9 distribution.

10 If it turns out we're wrong and we've been too  
11 conservative, perhaps we can revisit it. But our opening  
12 intent here was to not go after everything, just to try and  
13 get that tail.

14 MS. HANSEN: Thank you. Some of my other  
15 clarifying questions have been answered, but there's just  
16 one, because the magnitude and the difference of the three  
17 different recommendations are quite different relative to  
18 changing the payment system and then some accountability and  
19 then further study.

20 The question I still have on recommendation number  
21 two and the set of bullets underneath it is the necessity to  
22 put it in this format, one whereby there is no statutory

1 authority right now for CMS to require some of this  
2 documentation, because the documentation issues seem in some  
3 ways to be so straightforward that it would be a regulatory  
4 built-in requirement as a provider to not have a  
5 documentation of eligibility or recert and having a  
6 narrative. I mean, everything else is so basic in terms of  
7 plain accountability 101.

8           So I'm just curious that it just hits at this  
9 magnitude of being in a recommendation here versus something  
10 that CMS could require you to do.

11           MS. NEUMAN: We asked CMS whether they had the  
12 statutory authority to carry out these three tasks under  
13 recommendation 2(a). With an initial look at it, they felt  
14 that they did have that authority, so the way the  
15 recommendation is worded is the Congress should direct the  
16 Secretary. It leaves that sort of open. It's not saying  
17 that the Congress needs to enact the authority to be able to  
18 do this, but to direct CMS to carry out these steps which  
19 are within their jurisdiction.

20           And then the supporting narrative just urges the  
21 Congress to give CMS the resources to do some of these  
22 things, such as reviewing the stays in excess of 180 days,

1 because those kinds of things are very resource intensive,  
2 and as we have discussed previously, their resources are  
3 quite limited. So that was the motivation.

4 MS. HANSEN: But theoretically, bullets one and  
5 two are just kind of things that could be done, because I do  
6 understand the third bullet would require more resources.

7 MS. NEUMAN: It's our understanding that bullets  
8 one and two could be done under their current authority.

9 DR. DEAN: I'm not very familiar with the benefit  
10 in general, and I was curious, when a patient enters  
11 hospice, is there a requirement on the provider for a  
12 minimum level of service, or what does the provider commit  
13 to when the patient is enrolled?

14 And secondly, what specifically does the  
15 recertification require at the 180-day level? What's the  
16 wording or what specifically does the certifier have to  
17 verify or have to committed to?

18 MS. NEUMAN: I'll address the second part first.  
19 You're asking about current policy regarding what  
20 recertifications need to entail. So both the certifications  
21 and the recertification need to include basically a  
22 statement that the patient's prognosis is terminal given the

1 normal -- if the disease took its normal course. The  
2 physician would need to sign that piece of paper. There is  
3 no rationale as to why they are terminal or anything of that  
4 sort that's in the certification itself.

5           Then what needs to be in the medical record is  
6 information that if someone reviewed the record, they would  
7 come to the same conclusion, that the patient is terminal.  
8 But no sort of summary or anything of that sort, sort of  
9 looking at this record, this is why we think the patient's  
10 life expectancy is six months or less. That is currently  
11 the state of the rules.

12           What this recommendation would do, it would say to  
13 the physicians that they would need to, in the  
14 certification, put a brief statement as to why they think  
15 the patient's prognosis is terminal and that that would  
16 focus more attention on the eligibility criteria and  
17 physicians knowing that it's their responsibility to make  
18 sure that the patients actually meet it.

19           DR. DEAN: So at the 180-day time point, is the  
20 standard still that the patient is likely to die within  
21 another six months?

22           MS. NEUMAN: Yes.

1 DR. DEAN: So it basically extends the period  
2 another six months, and that can be done time and time  
3 again?

4 MS. NEUMAN: Exactly. So at every  
5 recertification, the criteria is, is the life expectancy six  
6 months or less at that point in time.

7 DR. MARK MILLER: [off microphone] And the  
8 certification is for 90 days?

9 MS. NEUMAN: The first two are 60, and then after  
10 that, they're all 90. Sorry. The first two are 90 and then  
11 after that 60. I apologize.

12 DR. MARK MILLER: So the decision is, or the  
13 clinical point is this patient is likely to die within six  
14 months, and the recertification is for 90, then 60 days.

15 MS. NEUMAN: Yes. Just to restate, because I have  
16 been unclear, so you have your initial certification. Then  
17 there's another recertification at 90 days. Then there's  
18 another recertification at 180 days. And then there's a  
19 recertification every 60 days after. That's the policy.

20 DR. DEAN: The other part of the question was what  
21 is the requirement when the patient enters? Is there some  
22 specific minimum level of service that is required, or is it

1 purely up to the provider?

2 DR. MATHEWS: There are a core set of palliative  
3 care services that the hospice has to be able to provide.  
4 So when the patient is admitted, the patient is assessed.  
5 An interdisciplinary team lays out a plan of care specific  
6 to that patient and identifies which of these core services  
7 the patient needs -- physician care, nursing care,  
8 counseling, social worker-type services, that sort of thing.  
9 But the regulation is not prescriptive as to any minimum  
10 level of service in any of those categories that needs to be  
11 provided to a given patient.

12 MR. HACKBARTH: Time for round two. Let me kick  
13 that off with a question and comment, because I want people  
14 to have a chance to react to it. Could you put up draft  
15 recommendation 2(a)? Kim, I think I detected in something  
16 you said that we may want to think about the level of  
17 specificity in bullet three, where we make a pretty specific  
18 suggestion that the medical director of the Medicare claims  
19 processing contractor should do some work. I thought I  
20 heard you say, well, maybe that should be broader language  
21 and that, in fact, CMS might prefer more latitude on that.

22 MS. NEUMAN: Yes. You could consider having not

1 just CMS's contractors, but also CMS potentially have that  
2 ability. So there could be more generic language considered  
3 there if you'd like.

4 DR. MARK MILLER: For example, could it read  
5 applicable Medicare contractor, or would you keep the  
6 medical director language in there, or would it just go from  
7 applicable to contractor?

8 Since you are conferring, I'm going to say from  
9 applicable to Medicare contractor, it would just say,  
10 applicable Medicare contractor.

11 DR. MATHEWS: The only reason we were hesitating  
12 there is that, given that what we are asking them to do is  
13 review the medical documentation related to determination of  
14 eligibility, you might want to have a clinician be  
15 responsible for this type of work rather than someone who is  
16 looking to make sure all the boxes are filled in.

17 DR. MARK MILLER: For purposes of the  
18 recommendation, if we said applicable Medicare contractor  
19 and talked about that in the text?

20 MR. EBELER: [off microphone] [inaudible]

21 DR. MARK MILLER: That's not a bad thought.

22 MR. HACKBARTH: If we have gotten a signal from



1 CMS that they would like a little broader language, I would  
2 like to accommodate them. This is the theme. Why don't you  
3 think about what that language should be while we go ahead  
4 with other round two questions and comments.

5 DR. SCANLON: I was going to make a comment about  
6 this in round two, which is that I was going to suggest that  
7 we just change it that the review is by CMS, and it could be  
8 a medical review, so that we make sure it is clinical. But  
9 there is this issue in legislation where something is  
10 designated to somebody and then that responsibility gets  
11 delegated. And I think it is fine here to delegate it to  
12 contractors. I see no reason, though -- not that this would  
13 tie CMS' hands, but that CMS could be doing some of these  
14 reviews themselves. And so just we want them done; kind of  
15 how they get done is the other issue.

16 DR. CROSSON: I'd like to congratulate both of you  
17 for this work. I think based on discussions we have heard  
18 in the past, the Commission is leading in this area, and I  
19 think that is something we should be proud of.

20 I have support for all three recommendations. I  
21 would like to bring up an ambivalence about part of  
22 recommendation number one, and that has to do with the

1 budget-neutral manner. Now, I think I can understand, given  
2 the moving parts here in all of these recommendations and  
3 the complexity of this, why one might want to start at a  
4 budget-neutral manner.

5           On the other hand, if you look at the relative  
6 profitability here -- and, again, I am referring to Figure 2  
7 in the text on page 10, which is the margins, most recent  
8 margins across the industry -- they look relatively high  
9 compared with some other segments that we have dealt with.  
10 So the middle of the distribution here is in the range of 8  
11 to 10 percent with the range going from minus 3 up to  
12 perhaps 20 percent.

13           So just in terms of how we think about increases,  
14 or not, in different categories of payment, what is the  
15 rationale for choosing budget neutral here? And should we  
16 reconsider that and actually, in view of what the CBO has  
17 scored here, think about something different?

18           MR. HACKBARTH: I've seen a number of heads  
19 nodding on that issue. Could I just get a show of hands of  
20 people who share that same concern about whether we want to  
21 use -- okay.

22           DR. REISCHAUER: Let me say something about that.

1 Unless we have evidence that we are underpaying the good  
2 actors, there is no reason to change the system in a way  
3 that takes money from the bad actors and boosts the good  
4 actors, I think which is what Jay's point is. You know, so  
5 if that is the case and we think that, you know,  
6 appropriately behaving hospices are getting margins that are  
7 about average, then we should take the money away.

8 DR. MARK MILLER: A couple of reactions to this.  
9 One, I wouldn't put a lot of weight on the CBO analysis,  
10 again, because given sort of the level of effort -- with no  
11 commentary intended there. It just wasn't an official piece  
12 of legislation, that type of thing. I think what drove us  
13 in this direction, with you guys doing close air support,  
14 is, one, remember also what each of you have expressed in  
15 every one of these conversations: Are we sure we are not  
16 doing any damage here? So I think that is part of what  
17 drove us in that direction. If I recall from back in  
18 November or whenever we looked at that, there is a pretty  
19 wide distribution in profitability here, maybe you could --

20 DR. MATHEWS: That is correct. And I would also  
21 again go back to my earlier caveat about Figure 2. This is  
22 not volume weighted, and so if you were to weight the

1 hospices by the volume of patients, there would be many more  
2 patients who would be seen by hospices at the lower end of  
3 the profitability distribution than there are in the higher  
4 end.

5           The second thing I would put on the table for you  
6 to keep in mind as you deliberate this point is that the  
7 relationship between length of stay and profitability that  
8 we have shown in Figure 2 and the impacts that we have shown  
9 here presume current law as it was prior to CMS' phase-out  
10 of a budget neutrality adjustment factor that began -- or it  
11 will begin this year, which will reduce payments over the  
12 course of a three-year period to a level 4 percent lower  
13 than they currently are.

14           So, again, just something to keep in mind that, in  
15 addition to the points Mark made, there is a certain amount  
16 of dynamism going on with respect to current levels of  
17 payments.

18           MR. HACKBARTH: In addition to that, as was  
19 pointed out earlier, we are talking about a system that we  
20 are saying goes into effect in 2013, and there will be  
21 opportunities between now and then to look at update  
22 recommendations if we are so inclined.

1           Just one other thought, Jack. There are a number  
2 of people in the room who have lots of experience with  
3 development and implementation of new payment systems. My  
4 sort of take on that over the last couple decades is that  
5 there is sort of a tradition that you do it budget neutral  
6 initially, and then you take the steps to alter the rates to  
7 squeeze out excess profit, and you separate those two steps.  
8 You do the redistribution in one step, and then you try to  
9 wring out the excess in the second and third steps.

10           You know, I think that there is --

11           DR. REISCHAUER: [off microphone] [inaudible]

12           MR. HACKBARTH: Right. I think that there is some  
13 wisdom in trying to separate new payment system development  
14 and redistribution of your payments from trying to wring out  
15 excess profit. So that is just a thought, and I would like  
16 people's reactions as we go around.

17           DR. CASTELLANOS: First of all, Jim and Kim, I  
18 think you guys did a great job. Jim, you really have  
19 brought us along over the past several months on the hospice  
20 issues, and I really appreciate your help and being able to  
21 talk to you about this.

22           As you know, I am a practicing physician. I was

1 just sitting here thinking. I go to a lot of meetings; most  
2 of them are medical meetings. And if this subject was  
3 brought up in a medical community with hospice people,  
4 physicians, nurses, the tenor would be entirely different.  
5 I think we can't forget to focus that we're dealing with  
6 people and we're dealing with people's lives and we're  
7 dealing with families. And there are some bad actors out  
8 there, but the majority of what is being done by hospice is  
9 excellent care. And we don't want to throw that baby out  
10 with the bath water. We really need to remember that they  
11 provide a tremendous service to this community, or to our  
12 community and society.

13 I have a couple of questions. One is I think we  
14 are focusing in on the long term, and by doing that we may  
15 be doing some harm with the short term, especially delaying  
16 people getting into hospice. And what you are going to do  
17 is keep these people in the acute phase of reimbursement  
18 with Medicare. And I think, Mark, you mentioned that.

19 We have all seen the tremendous costs in the last  
20 six months of life. We had the discussion where the Mayo  
21 Clinic compared to UCLA in increased costs, and I just have  
22 some concern that we are focusing on the long-term bad

1 actors, but there are some short-term bad actors, too.  
2 These patients aren't getting in. They are staying in the  
3 acute side, and these expenses are extremely high. So we  
4 need to focus in.

5 First of all, I agree with all the  
6 recommendations. Can we go to recommendation number two?  
7 You know, what we are doing is making medical decisions for  
8 financial reasons, but I think what we also need to do is  
9 make sure we -- and we haven't really stressed it with the  
10 hospice physician and the referring physician. We need to  
11 stress the appropriateness -- and by that I mean the  
12 appropriate referral to hospice when the patient elects this  
13 benefit. We really may even think about an education  
14 process, because I think that is where we need to do it. I  
15 think what we need to really do is focus in to make sure  
16 what is happening is being done appropriately on a medical  
17 decision, not just a financial decision.

18 Kim, the other issue I have is -- you talked about  
19 a little the fiscal intermediaries, the medical contractors,  
20 and I can remember, Jim, we had several discussions on this.  
21 I think there were four or five medical contractors, and it  
22 seemed that one of them was the one that stood out like a

1 sore thumb. And, you know, we talked about it last meeting,  
2 and you said you looked at it and you didn't see anything.  
3 But there were some variations in the pattern between the  
4 different hospice providers. Maybe they were local carrier  
5 decisions, but maybe we could uniformly get everybody on the  
6 same level playing field with administrative contractors.

7 I really think, Kim, you kind of pointed out a  
8 little bit about maybe we need a little bit more supervision  
9 or looking at the fiscal intermediaries, the medical  
10 contractors.

11 But, again, what I want to stress here is that  
12 there is no precision in determining end of life. We all  
13 have our decisions. We all think we know what is going to  
14 happen. But sometimes it doesn't work. And as a doctor,  
15 when a person lives a little longer and has quality of life,  
16 we pat ourselves on the back and said, great. We did a good  
17 job.

18 Thank you.

19 DR. SCANLON: Three quick points. First of all, I  
20 agree completely with you, Glenn, in terms of the idea of  
21 budget neutrality. One of the things that you are talking  
22 about in proposing a payment system change to policymakers



1 is that you have got to -- there is a level of uncertainty  
2 about what the impacts are going to be, and you really need  
3 to be reassured that we are not going to cause harm. And so  
4 to combine sort of the idea that we are going to both take  
5 away money and restructure things increases the risk of  
6 potential harm. There are examples you can point to where  
7 we did things budget neutral and over time we have made  
8 adjustments that have improved upon the efficiency of the  
9 system. So I think it is a wise thing to do this in stages.

10           The other two things: One is, I guess, in terms  
11 of the text of the chapter with respect to oversight, I  
12 think that we should emphasize that we are not proposing  
13 that these medical reviews in the third bullet in 2(a) be  
14 the only medical reviews that are going to be done. These  
15 should be in addition to medical reviews that are currently  
16 sort of underway, because one thing you don't want to do in  
17 terms of program integrity is to say here is exactly what I  
18 am going to look at, and so if you do anything else, you are  
19 going to be fined. You want to be able to have some more  
20 targeted options in terms of review.

21           The last thing is with respect to sort of the  
22 issue of the nursing homes. To me it is not just a question

1 of conflict of interest, though there may be an aspect of  
2 that. To me it is more of a question of does residence in a  
3 nursing home change the hospice benefit, even in the best of  
4 circumstances. And does it change it in a significant  
5 enough way that you need to think about a payment system  
6 that differentiates between residents of nursing homes and  
7 non-residents of nursing homes?

8 I think that we have been handicapped by a lack of  
9 data about actually what services are being provided. But  
10 to the extent that we can explore that, and maybe some for  
11 the fall, and then as data comes in in the future, that to  
12 me should be one of the questions on the table: How is the  
13 nature of the benefit changed by residence in a nursing  
14 home?

15 MR. HACKBARTH: One of the things I want to  
16 accomplish in this round is try to build towards changes, if  
17 any, in the recommendations so we can get people to react as  
18 we go through the queue. So what I hear Bill putting on the  
19 table is a couple points that I would like people to react  
20 to. One is stick with the budget neutrality language, but  
21 we could have a discussion in the text that expresses our  
22 concern about the trends, and we think that there may well

1 be opportunities through the update process, and after the  
2 payment system is in place, to reduce projected future  
3 expenditures. So people shouldn't interpret budget  
4 neutrality as we think aggregate spending levels are just  
5 fine, but we are advocating that as part of the appropriate  
6 way to do a payment reform. So that is one idea to react  
7 to.

8           The other is to go to broader language in the  
9 third bullet of 2(a) and then to have some discussion in the  
10 text about the need for medical review of the activities  
11 here. So if people will react to those as we go through.

12           DR. STUART: Bill raised the point that I was  
13 going to raise. You've made clear that recommendation one  
14 applies only to home care hospice, and as I recall from the  
15 text in the chapter, that is about 82 percent of hospice  
16 patients. It is the majority of hospice patients.

17           DR. MATHEWS: I think more than that. It is over  
18 90.

19           DR. STUART: But the point I want to make here is  
20 that the way the chapter reads, we go up to the information  
21 that supports draft recommendation one, and then there is a  
22 short section that talks about institutional hospice care.

1 And then that is followed by recommendation 2(a) and 2(b),  
2 and the implication is, well, we can handle the issues in  
3 institutional hospice care through these reviews on a case-  
4 by-case basis, but there is really no discussion about how  
5 we are moving toward payment reform in the institutional  
6 care. And so I guess it really is the point you were  
7 raising, Mark, that this is something that is on the desk  
8 for future review.

9 I will say on the budget neutrality issue, because  
10 this is, I think, really important, I would like that to be  
11 an issue in and of itself. I would really like to see what  
12 has happened to each of these as we have gone, starting with  
13 PPS for the hospitals, and then moving onward, what the  
14 impact of starting with budget neutral and then changing  
15 that afterwards. Because my take on this is that in almost  
16 every one of these cases, there is just a real bloom in  
17 profitability right after the implementation, and then it  
18 goes down. Now, whether it goes down because of what, I am  
19 not sure. I mean, clearly there is a reaction/counter-  
20 reaction. But I think that it would be very useful for the  
21 Commission as a whole to have kind of that longer history  
22 and just to see how that has played out.

1           MR. HACKBARTH: I think that is a good suggestion,  
2 Bruce, and I think we all have remarked, led by Nancy, on  
3 the history of the post-acute PPS systems in particular very  
4 much fit the pattern that you describe. And so I think that  
5 is a real issue. The question I am trying to raise is do  
6 you try to do it in one step or in two steps.

7           DR. KANE: Just to comment on what you just talked  
8 about, the post-implementation period represents high  
9 profit, but then what you see is rapidly rising cost, you  
10 know, following those high profits, the ability to spend  
11 more money. So I do think we should think about it because  
12 I am not sure we are really lowering -- I am not sure we are  
13 really achieving the kind of cost savings that we would like  
14 to achieve. And I agree with Bob that it is not clear to me  
15 why you would start to pay more for the early phase if, in  
16 fact, people are -- that is not why people are losing money  
17 now. I think we need to know better why there are losses in  
18 some hospices and whether it is because they are only short-  
19 stay patients.

20           We also don't really like short-stay hospice, so I  
21 am not so sure we want to reward those either, and I am very  
22 concerned that we might sort of do those little three-day to

1 two weeks, more of those, instead of achieving of what we  
2 really would like to see which is a dignified, home-based,  
3 end-of-life experience.

4 I was reacting a little bit to your comment about  
5 marginal costs and having tried to actually do that in life,  
6 I don't recommend it because in the real world it is really  
7 a function of how people are hired. This is a very labor-  
8 intensive service, and if people are hired on a per diem  
9 basis, they are marginal. If they are hired on a salary  
10 basis, they are fixed. You don't want to go there.

11 But I think what is really driving the curve that  
12 I see is the skill mix and the number of visits, and you  
13 want the payment system to reflect the skill mix and number  
14 of visits at different stages of the episode. And perhaps  
15 that would be a better principle to work off than this kind  
16 of nice economic notion, theoretical notion of marginal  
17 cost, which you can almost never get to in the short run.  
18 In the long run, everything is marginal. So I would just  
19 say aim to try to reflect what the normative visit and skill  
20 mix is throughout the episode as a payment device rather  
21 than some theoretical marginal cost.

22 Then my final comment goes back to what Ron was

1 saying about how important it is to really try to -- I think  
2 the hospice benefit was really there to try to get people in  
3 before the amazing, enormous expenditure on the acute sector  
4 that many people feel are wasteful. I know it is a very  
5 tough issue, and, therefore, we are trying to not deal with  
6 it. But it seems that that is the issue. That seems to me  
7 far more important in some ways than the long stays, is the  
8 people who don't get in or get in for the last two or three  
9 days. I know it is hard, but I am just wondering if more  
10 reflection, more investigation, more discussion will give us  
11 some way of thinking about how do we try to bring the system  
12 to doing the right thing rather than, you know,  
13 overtreatment and excess expenditure in the acute sector at  
14 the end of life.

15           So I don't have the answers, but it seems like we  
16 dismissed it saying it is just too hard, and I don't think  
17 that -- since that is what we really want this benefit for,  
18 I think we need to think harder about how do we get  
19 providers and families and beneficiaries to be more aware  
20 and more willing to accept that this is the end of life and  
21 let's do something that is more dignified than what can  
22 happen.

1 DR. MATHEWS: In the expert panel that we convened  
2 in October of last year, we had four major agenda items, and  
3 one of them was this very question of what are the causes of  
4 the very short-stay patients and what can be done to try to  
5 change those three-day stays to ten-day stays or two-week  
6 stays and begin to move the distribution that way.

7 DR. KANE: But we don't really address it very  
8 much in the payment.

9 DR. MATHEWS: That's correct. The short version  
10 of what transpired in the panel was they were not  
11 optimistic. And we can have a conversation off-line about  
12 some of the detailed things they discussed, but there is a  
13 reason that it is not reflected fully in the paper.

14 MR. EBELER: This is terrific work, and I am  
15 supportive of the recommendations. Two comments, then a  
16 suggestion.

17 On the budget neutrality question, if we go back  
18 to the history, PPS was budget neutral, but it was budget  
19 neutral against what was called the TEFRA baseline, which  
20 was a set of very, very aggressive hospital cost constraints  
21 that had been enacted in the previous year. Likewise, RBRVS  
22 I think was budget neutral, but we had in the interim taken



1 several whacks at specialty payments. So there is also a  
2 history of some sort of arbitrary directional cuts before  
3 one implements the prospective system.

4           In hospice, we haven't mentioned it, but I would  
5 note that we still have the hospice caps in place and would  
6 presumably remain in place until 2013, and which capture the  
7 -- recapture some of the payments that go out for these  
8 exceptionally long stays. So I think when we are talking  
9 about budget neutrality here, it would be neutrality  
10 including the recapture that comes from those caps.

11           Second, if you would go to recommendation 2(a),  
12 this text comment at the bottom, I think more generically in  
13 this report we do need to continually point out that CMS is  
14 a very resource-constrained agency that everyone is asking  
15 to do a set of very, very innovative things, and I think we  
16 need to speak very clearly that if we want this program run  
17 right, we are going to need to resource it.

18           On bullet point three, I want to just make a  
19 suggestion that I think captures what Bill has suggested.  
20 The policy in bullet point three is that for outlier stays  
21 at hospices that appear to have a lot of outlier stays, we  
22 want medical review. That is the policy statement here. My

1 suggestion for us -- we are going to need something to vote  
2 on -- is that we insert the word medically before reviewed,  
3 and then delete everything from by the applicable up to for.  
4 So that is says require that all stays in excess of 180 days  
5 be medically reviewed for hospices for which... and then go  
6 on there. We don't say who does it. We just say we want it  
7 to be medical and we want it to be at these targeted places.

8 I hope that captures what you would suggest.

9 MR. HACKBARTH: I see some heads nodding. If we  
10 can nail that down, does that make sense to people?

11 [simultaneous inaudible discussion]

12 MR. EBELER: We want them reviewed. The mechanism  
13 for review I don't -- I think --

14 MR. HACKBARTH: Not reviewed by the hospice.

15 MR. EBELER: Not by the hospice. I'm sorry. Yes,  
16 that's right.

17 MR. HACKBARTH: We're okay on that point. People  
18 feel comfortable on that.

19 MR. BERTKO: I'm just going to quickly support  
20 your idea, Glenn, of the two-part, first make the change to  
21 redistribute, and then go after the budget-neutral part of  
22 it; and point out in Jay's -- the thing that he pointed

1 here, that there is apparently some reason to pay more for  
2 those very short stays. I've heard that also from several  
3 hospices, but that is one of the places in the U-shaped  
4 curve that probably needs immediate attention.

5 MS. HANSEN: Thank you. Yes, I support the  
6 changes that have been recommended, and after hearing the  
7 discussion about the two-part aspect, I would go along with  
8 that.

9 The one question I would have as we have this  
10 great work in this chapter, I wonder if there is content  
11 related to quality about the hospices. I don't know if  
12 there is any text at this point or some measures, but part  
13 of it is what services beyond the individuals that we have.  
14 So I wonder if that could be in the body of the text  
15 relative to the quality aspects of hospice.

16 MR. GEORGE MILLER: Thank you, and again, I want  
17 to congratulate the staff on excellent work in this chapter.  
18 I can support the recommendations. Jennie just covered my  
19 issue about quality, and I will check that off. But I agree  
20 with that.

21 Along with the quality, it seems to me -- and I  
22 agree with Ron this is an excellent benefit. We certainly

1 don't need to throw the baby out with the bath water. But  
2 using your metaphor, the water needs to be changed and it is  
3 toxic with some of these actors, and I am concerned about  
4 them. And I think that a part of it is -- I don't know if  
5 we put in the text, but there also needs to be some  
6 education of the beneficiary. This is a great benefit, but  
7 the way some of them are getting this benefit may be  
8 misleading from some of the evidence. It reminds me, if  
9 this is a good metaphor, of the credit card industry. They  
10 want everybody to get one, and then they do other things  
11 with the interest rates and those types of things to get  
12 everybody to get -- including my three kids, get offers for  
13 credit cards. Nonetheless, the benefit is great if the  
14 beneficiary is properly educated about the benefits, what  
15 hospice can do and should do for them at the appropriate  
16 time. So I would imagine we need to put that in the text.

17 But, again, just to emphasize the point as we look  
18 at this benefit and this cost -- and I would agree we need  
19 to study it over time. But I am concerned about the  
20 statement about budget neutrality that I think either Jay or  
21 Bill brought up, and we will address it at the appropriate  
22 time.

1 Thank you.

2 MS. BEHROOZI: This is an incredible amount of  
3 work you have done in a short period of time, and as I often  
4 hesitate to ask you to add a little thing, I will get to  
5 that in a second, just to address the budget neutrality  
6 point.

7 A point that you have made very clear is that  
8 there are probably beneficiaries receiving this benefit who  
9 shouldn't be, because they exceed the length of stay,  
10 exceed, exceed, and then they ultimately leave and maybe  
11 come back again. You know, we won't talk about Mike's  
12 grandmother, but -- so that extra money associated with  
13 those extra people in the system, it is not just that their  
14 stays are too long, but they shouldn't be in the system.  
15 And one of the things you're trying to do with changing the  
16 payment methodology is to have hospices select in the first  
17 instance more appropriate patients.

18 So if that reduces the number of people in the  
19 system, it does seem kind of odd to then take all that money  
20 that is associated with all those extra people and  
21 redistribute it to the beneficiaries that are left, to the  
22 providers who are treating the beneficiaries who are left.

1           So it seems like some kind of adjustment to the  
2 budget neutrality is in order, and maybe what Jack said  
3 about the cap addresses that. And I can't think of any  
4 other way to address that. It is not just a matter of, you  
5 know, reducing profitability. It is about keeping people in  
6 a more appropriate end-of-life setting. So that is a  
7 thought on budget neutrality.

8           The thing that I would suggest adding, it is kind  
9 of minor point, but could you put up recommendation 2(a),  
10 actually the -- I'm sorry, 2(b). This is a little bit, I  
11 guess, spurred by what Peter said about having the OIG come  
12 knocking on your door is a big deal, particularly for those  
13 who would be targeted by the third and fourth bullets.

14           If you could go to the next page where it says  
15 there is no spending implications, I get that that is the  
16 way the CBO would score it, and I wouldn't -- and we are not  
17 making any recommendation of action in those bullet points.  
18 But I do think in the text it is worth saying that we would  
19 anticipate -- I would anticipate; I don't know if you would  
20 agree -- a sentinel effect on the far outliers. And it is  
21 just the far outliers, and it is not core to the program,  
22 and possibly an impact that would be protective of

1 beneficiaries, as George says, because, you know, you make  
2 the point earlier in the text that maybe people who are  
3 targeted may be cognitively impaired or whatever, and they  
4 have to give up treatment for their terminal condition,  
5 which may or may not be their choice, may or may not be the  
6 best thing overall. But they may be robbed of a choice by  
7 virtue of some of that behavior that would be kind of tamped  
8 down by this sentinel effect.

9 MR. BUTLER: Well, us first-timers weren't here  
10 for the panel. I wish I had been. But listening to all  
11 this, I think, again, what everybody else has said, of all  
12 the things I've sat through in the last year, I think this  
13 is an exceptional kind of contribution that we're making,  
14 and I would like to acknowledge that. And as I think about  
15 my nitpicking on some of these recommendations, I am  
16 deciding I am not concerned at all. Yesterday, we had to be  
17 precise and feel like we are doing the right thing. Here I  
18 think to throw out a broad range of things to advance the  
19 discussion is very good, and we shouldn't worry about if we  
20 are little bit off on some of these. We've created a  
21 baseline that is very robust, and we will have plenty of  
22 dialogue in plenty of places. So I am very supportive of

1 it, not really concerned about the wordsmithing so much. So  
2 I am supportive of the recommendation.

3           The second thing, though, that I'm feeling uneasy  
4 about -- and it was triggered first by Ron -- is that of all  
5 the benefits we look at -- and this is largely Medicare  
6 expenses -- it is not just a financial statement about  
7 trying to use resources at end of life. It is kind of a  
8 social statement of how we handle end-of-life issues in this  
9 country. And we don't kind of capture how we can advance  
10 the softer side of this, not just the mechanics of this in a  
11 way that create the kind of dialogues. And I don't know how  
12 -- we don't typically make those recommendations because it  
13 comes down to budget kinds of things. But if there's a way  
14 we can capture some of that, I think that would be  
15 important.

16           Along those lines, and also along these lines, of  
17 all the areas where I would like to hear plenty of public  
18 comment and dialogue, this is a good one to hear from the  
19 constituencies that can help educate us as a group.

20           DR. CHERNEW: This is a really a round one  
21 comment, which is related to something that Bill said at the  
22 very beginning of this round, which is I am confused as to



1 what Part A and Part B services are foregone if a person is  
2 in hospice and how that is actually enforced. And I am  
3 interested in how that then is bundled with the nursing home  
4 set of services.

5 DR. MATHEWS: The foregone services are those  
6 curative treatments related to the terminal condition, so  
7 the --

8 DR. CHERNEW: But other treatments that are either  
9 not curative -- so palliative treatments or things that are  
10 not related to the terminal condition are -- so we don't  
11 know exactly how much Part A and Part B services are being  
12 used by hospice beneficiaries.

13 DR. MATHEWS: That is correct.

14 MR. HACKBARTH: Okay, this has been a good  
15 discussion. We are about 15 minutes behind schedule, and  
16 this being Friday and people having planes to catch, we  
17 really need to finish the day on time. So we have got to  
18 bring this to a conclusion.

19 I want to offer two proposals based on the  
20 discussion for modifying the recommendations, and let me do  
21 the easier one first. On 2(a), what I would propose is the  
22 Ebeler amendment, which is to say in that third bullet that

1 all of the stays should be medically reviewed and then drop  
2 the detail, and in the text we can make it clear that, you  
3 know, we are talking about external review and not just the  
4 hospice review. So that is the change.

5 Now, if people want to see the actual changed  
6 language, we can defer the vote until after the last  
7 discussion. I think that one is pretty simple and doesn't  
8 really require us doing a new slide. Are people comfortable  
9 voting that way? Okay. So that is 2(a).

10 Then go to draft recommendation one. This one is  
11 a little bit more complicated -- not the change, but the  
12 issues raised are inherently complex issues. My proposal  
13 for changing the recommendation is simple, which would be at  
14 the end there where it talks about budget neutral, say  
15 budget-neutral manner in the first year. Add the words in  
16 the first year at the end. And then add in the text a  
17 paragraph that (a) makes it very clear that that shouldn't  
18 be interpreted as satisfaction with the level of spending or  
19 the growth in spending in hospice; and (b) says that there  
20 are other policy tools that can be used between now and 2013  
21 and afterwards to address the level of spending, including  
22 updates, the cap, and medical review.

1           Let me stop there. I will just end up repeating  
2 myself. So that is the proposal that I would make.

3           DR. KANE: What's the timeline on when our  
4 recommendations are required to be -- just refresh my memory  
5 of why we have to vote on these as is today rather than in  
6 March?

7           MR. HACKBARTH: The only reason would be to  
8 include them in the March report as opposed to the June  
9 report, which has been our goal. I don't know what it would  
10 do logistically to defer a final vote to March and putting  
11 this in the June report as opposed to the March report.

12           DR. MARK MILLER: It does mean it doesn't go into  
13 March, and then whatever agenda that we have for June -- and  
14 some of it is mandated -- there are a couple mandated  
15 reports we have to work through. So it starts to --

16           MR. HACKBARTH: Push other things off the plate.

17           DR. KANE: My only concern is really I think some  
18 of us did say we are not sure you should increase the  
19 payments equal and offsetting the ones you reduce and that  
20 we are not sure the lack of profitability relates to the  
21 early stays as opposed to just maybe something else like low  
22 volume. I guess that is -- I got the feeling we don't feel

1 -- I don't feel fully informed about the increased payment  
2 per day at the beginning piece that is equal and opposite to  
3 reducing the payment at the end -- at the middle, I mean.

4 DR. MARK MILLER: But remember, we are not -- the  
5 illustration that we put up on the slide that shows an  
6 equal, you know, beginning and end is just that. It is an  
7 illustration.

8 DR. KANE: I think the budget neutrality sort of  
9 says basically what you take away from the end where we --  
10 from the middle where we think it's overpayment. You add to  
11 places where we are not sure it is overpayment --  
12 underpayment.

13 MR. HACKBARTH: I think I understand your concern,  
14 and I think it is a good one. What we have done is lay out  
15 a concept about what the weights ought to look like. We  
16 haven't proposed specific weights, but we have suggested  
17 this U-shaped curve, which basically is a system of relative  
18 values. And we are saying the early days should be more  
19 highly paid than the middle days and so on.

20 That is not a statement about the absolute value  
21 of the rates during the early days and whether it ought to  
22 be higher than today or lower than today. You know, to use

1 the language of the Physician Payment System, that would be  
2 a question of the conversion factor, not the relative  
3 values. So I think our recommendation is one of a  
4 conceptual recommendation about the relative values and what  
5 that shape ought to look like. And what we are saying is  
6 the conversion factor is a separate issue. And the  
7 paragraph I have described says we have some concerns about  
8 the conversion factor, some concerns about the aggregate  
9 level of spending and the growth in spending, and those  
10 ought to be addressed through other policy measures like  
11 updates and cap and medical review in the interim.

12 So I wouldn't view the U-shaped curve that we are  
13 talking about as advocacy of higher payments than the  
14 existing level. It may work out that way; it may not work  
15 out that way.

16 DR. KANE: Then your language would have to not  
17 say increased payments per day. It would have to say have  
18 the payments per day be relatively higher than those of the  
19 length of --

20 MR. HACKBARTH: I think that is a good suggestion.

21 DR. SCANLON: If people were comfortable with that  
22 kind of a change, I think it is important, if we can, to get

1 this into the March report, because the March report has  
2 hearings associated with it. And getting this before the  
3 Congress as they are considering this year what they are  
4 going to do with Medicare, it is important that they think  
5 about this.

6 MR. HACKBARTH: I think that is an excellent  
7 point, Bill.

8 MR. EBELER: And we're not going to have the data  
9 to answer your question until 2010 or 2011. We are not  
10 going to have that in March.

11 DR. KANE: I'm happy with the language that  
12 doesn't say increased payment but says have payment in the  
13 early stay relatively higher than payment in the -- just  
14 change that word.

15 MR. HACKBARTH: We're going to move to a vote in  
16 just a minute. So, Nancy, do you want to state very clearly  
17 your rewording of that language?

18 DR. KANE: That we recommend that payment in the  
19 beginning of the episode be higher than payment per day as  
20 the length of the episode increases, and that payment at  
21 death should be relatively higher than payment in the middle  
22 of the episode.

1                   MR. HACKBARTH: People have got that and feel  
2 comfortable with it? Mark?

3                   DR. MARK MILLER: See if this captures it. I  
4 think it is fewer word changes. What you do is you  
5 substitute increased with relatively higher at the  
6 beginning. So it would say relatively higher payments at  
7 the beginning of the episode, relatively lower payments per  
8 day as the length of stay continues, and then in the second  
9 bullet it says relatively higher payment. Okay? And it's  
10 just a couple -- right, we are just swapping out a few words  
11 on this.

12                  MR. HACKBARTH: Okay, any questions of  
13 clarification about that? We are going to vote in just one  
14 minute. We are going to vote in ten seconds. We are going  
15 to vote now.

16                  [Laughter.]

17                  MR. HACKBARTH: On recommendation one, all opposed  
18 to recommendation one? All in favor? Abstentions? Okay.  
19 So recommendation 2(a) with the Ebeler amendment in bullet  
20 three. All opposed to 2(a) as amended? All in favor?  
21 Abstentions?

22                  Recommendation 2(b), all opposed? In favor?

1 Abstentions?

2 And Recommendation three, all opposed? In favor?

3 Abstentions?

4 Okay. We are done. Thank you very much.

5 Next is our MIPPA mandated report on Medicare

6 Advantage.

7 MR. EBELER: If folks could take their seats. We

8 need to move along here. We're a little bit behind time.

9 Scott, when you're ready, you should...

10 DR. HARRISON: Good morning. Today, I will

11 present some preliminary simulations for the Medicare

12 Advantage payment report that was mandated for us in MIPPA.

13 Remember our mandate: We've been assigned three specific

14 tasks. Over the past few meetings, we've discussed

15 evaluating CMS's measurement of county-level fee-for-service

16 spending, and the correlation between that spending and MA

17 plan costs as represented by their bids.

18 At this meeting, we are examining alternate

19 approaches to MA payment in addition to the county fee-for-

20 service approach. I am first going to remind you of

21 MedPAC's past position and recommendations on Medicare

22 Advantage payment, and then I'm going to discuss some



1 alternatives and present some simulations of the  
2 alternatives.

3           MedPAC has a long history of supporting private  
4 plans in the Medicare program. The Commission believes that  
5 the beneficiary should be given a choice of delivery systems  
6 that private plans can provide. Private plans, through  
7 financial incentives, care coordination, and other  
8 management techniques, have the potential to improve the  
9 efficiency and quality of healthcare services delivered to  
10 Medicare beneficiaries. And if the plans are paid  
11 appropriately, plans would also have the incentive to be  
12 efficient for the Medicare program and for the taxpayers  
13 that support Medicare.

14           However, MedPAC has expressed concern that the  
15 payment system is not financially neutral in a beneficiary's  
16 choice of enrolling in an MA plan or remaining in fee-for-  
17 service Medicare. Because the system does not adhere to  
18 financial neutrality, excessive payments to plans have been  
19 attracting inefficient plans to Medicare Advantage. More  
20 specifically, Medicare is paying 14 percent more for  
21 beneficiaries to enroll in a plan than it would cost to  
22 cover those beneficiaries under fee-for-service Medicare.

1 The extra cost has been subsidizing plans, often private  
2 fee-for-service plans that are not designed to coordinate,  
3 care, and improve quality, and even the subsidies are not  
4 spent efficient efficiently, especially those for private  
5 fee-for-service plans. The Medicare program pays a subsidy  
6 of \$3.26 for each dollar of enhanced benefits for private  
7 fee-for-service enrollees. That subsidy is funded by  
8 taxpayers and by higher Part B premiums paid by all Medicare  
9 beneficiaries, whether they are in MA plans or not.

10 So, to address the financial neutrality concerns,  
11 the Commission recommended that Congress set Medicare  
12 Advantage benchmarks at 100 percent of fee-for-service  
13 costs.

14 MIPPA asks us to examine alternate approaches to  
15 MA payment. Specifically, we are asked to examine  
16 approaches other than the approach using payments based  
17 purely on county-level fee-for-service spending. In  
18 previous meetings, we have discussed enlarging the payment  
19 areas to create greater stability and to better approximate  
20 insurance markets, and we have discussed using a blend of  
21 local and national fee-for-service spending to set the  
22 benchmarks. Today, we will simulate some alternative

1 benchmark setting formulas, including the blend.

2           For today, we simulated the effects of five  
3 different formulas that could be used to set benchmarks.  
4 First, we looked at current law and we looked at one version  
5 of our prior recommendation that would set benchmarks equal  
6 to 100 percent of local fee-for-service spending. These two  
7 options serve as good points of comparison.

8           We also examined simply setting all benchmarks  
9 across the country at a 100 percent of the national average  
10 fee-for-service spending.

11           In addition, we looked at two approaches that use  
12 both national fee-for-service spending and local influences.  
13 First, we took the national fee-for-service average and  
14 adjusted it for local price differences but not for  
15 utilization differences, and we simulated the 75 percent  
16 local/25 percent national blend that aims to recognize plan  
17 costs, which we discussed last time. I will now go into  
18 more detail on each alternative.

19           I'm going to show you a series of simplified  
20 graphical representations of each of the formulas. Imagine  
21 the counties arrayed along the bottom in order of fee-for-  
22 service Medicare spending in the county. The corresponding

1 benchmarks run up the site. So, a point on the graph would  
2 represent the fee-for-service spending in a county and the  
3 benchmark for that county under whatever alternative we are  
4 discussing. Here, the orange line represents setting the  
5 benchmark at 100 percent of the county or local fee-for-  
6 service spending.

7           The yellow lines show the simplified relationship  
8 between fee-for-service spending in the current benchmarks.  
9 Basically, the benchmarks cannot go below the floor, and  
10 above the floor, benchmarks theoretically are slightly above  
11 local fee-for-service spending. For visual simplicity, we  
12 are ignoring the fact that there are actually two floors,  
13 and that benchmarks can be significantly above fee-for-  
14 service if spending in the county has grown slower than the  
15 national average at some point since 1997.

16           Now, we're going to add a horizontal green line  
17 that represents setting all the benchmarks at 100 percent of  
18 the national average fee-for-service spending. In our  
19 simulations, the current benchmarks are always above the  
20 national average, but the national average is higher than  
21 fee-for-service spending in most rural and in many urban  
22 areas.

1           For some of the highest fee-for-service spending  
2 counties, this means that their benchmarks would decline by  
3 several hundred dollars per member per month, while some of  
4 the lowest spending counties would have benchmarks a couple  
5 of hundred dollars per member per month above their fee-for-  
6 service spending. This option has been suggested to  
7 resemble how payments work in Part D. In Part D, all plans  
8 are paid the same rate across the country; however, the  
9 benchmark is set by the average plan bid, not average fee-  
10 for-service spending.

11           Here, we look at using the national average fee-  
12 for-service spending to set benchmarks, except that we  
13 adjust the average to recognize local differences in the  
14 prices of health service inputs. We use the two primary  
15 Medicare price indices, the hospital wage index, and the  
16 geographic adjuster that is part of the physician fee  
17 schedule. This formulation would set benchmarks higher in  
18 areas where plans might be expected to have to pay providers  
19 more, but would not set higher benchmarks based on higher  
20 service utilization.

21           The cloud around the national average line  
22 illustrates that there is almost no relationship between

1 local fee-for-service spending and local price levels.  
2 Areas with similar prices can have very different fee-for-  
3 service spending patterns. This alternative would keep the  
4 range of benchmarks to a fairly narrow range relative to the  
5 range in local fee-for-service spending.

6 Note here that we've added points representing  
7 Minneapolis and Miami. Despite the fact that fee-for-  
8 service spending in Miami is about \$400 per month higher  
9 than in Minneapolis, average prices are about the same. And  
10 actually, if the benchmarks were set at the national average  
11 price adjusted fee-for-service spending, Minneapolis would  
12 have a slightly higher benchmark than Miami.

13 For the last alternative today, recall that  
14 Congress asked us to look at an alternative where the  
15 benchmarks might recognize the underlying costs of plans.  
16 The last time we presented on alternatives, we found that a  
17 blend of 75 percent of local fee-for-service spending and 25  
18 percent of the national average fee-for-service spending  
19 best approximated plan costs as expressed by plan bids. The  
20 white line here represents a 75/25 local/national blend.  
21 Benchmarks in areas with less than national fee-for-service  
22 spending, say, rural Nebraska, would be higher than their

1 local fee-for-service spending in areas with spending above  
2 the national average -- Miami, again, for instance -- would  
3 see benchmarks lower than local fee-for-service spending.

4           We modeled each of the alternative benchmark  
5 formulations with data from 2009 plan bids. We included all  
6 plan types, but we have excluded special-needs plans and  
7 employer group plans because they are only available to  
8 subgroups of Medicare beneficiaries. The results I will  
9 present assume that plan bids and service areas do not  
10 change. Of course, we would expect that any overhaul of the  
11 benchmarks would cause plans to change their bidding  
12 strategies, but we do not model any behavioral assumptions.  
13 We could imagine, however, that any change that would result  
14 in the reduction of benchmarks is likely to cause some plans  
15 to leave the market and beneficiaries to refrain from  
16 joining plans who do not pay far enough below the new  
17 benchmarks to offer more attractive benefits.

18           The simulation results that follow focus on plan  
19 availability. We compare plans 2009 actual bids with the  
20 new benchmarks that result under each alternative. We  
21 assumed that plans that bid below the simulated benchmarks  
22 would continue to do so and therefore be available, although

1 the extra benefits they offer would probably be reduced. We  
2 assumed that plans bidding above the benchmarks would not  
3 stay in the program because they would not be able to offer  
4 attractive benefits, although there are some plans that have  
5 bid above the current benchmarks and remain in the program.

6 So, the results today are based on very simple  
7 assumptions, and to maintain simple assumptions we performed  
8 the simulations at the county level not at the level of our  
9 larger recommended payment areas.

10 So, we simulated the benchmarks for each county  
11 under the alternatives below. The current benchmarks  
12 average about 118 percent of fee-for-service. Each of the  
13 alternatives would result in an average benchmark of around  
14 100 percent of fee-for-service. This reduction, regardless  
15 of the distributional effects, will cause a big change in  
16 plan availability. The plan shows the percentage of  
17 Medicare beneficiaries who live in counties with zero, one,  
18 or two or more plans bidding below the simulated benchmarks.  
19 Aside from rounding issues, each row here sums to 100  
20 percent. Currently, 100 percent of beneficiaries live in  
21 counties with two or more plans bidding below the benchmark.

22 Under our simulation rules, if benchmarks were set



1 at 100 percent of local fee-for-service spending, than 19  
2 percent of beneficiaries would be in counties where no plans  
3 bid below the benchmark, 12 percent would be in counties  
4 with one plan bidding below the benchmark, and 70 percent  
5 would be in counties with two or more plans bidding below  
6 the benchmark. This is the option that had the largest  
7 effect on the simulated plan availability.

8           The alternative that the least impact on the  
9 availability of plans bidding below the benchmarks was  
10 setting all benchmarks at 100 percent of national average  
11 fee-for-service. The simulations show that only 6 percent  
12 of beneficiaries live in counties where no plan bid was  
13 below the national average. The two alternatives that aimed  
14 to recognize local price differences or plan costs had  
15 intermediate and similar impacts to each other.

16           For more analysis, we will take the first column  
17 here and break it into urban and rural numbers on the next  
18 slide, but before I leave this slide, I want you to focus on  
19 the 90 in the right-hand column. It says that 90 percent of  
20 beneficiaries would have two or more plans available if all  
21 benchmarks were set at the national average fee-for-service.  
22 What it can't tell you is what kind of plans they might be.

1 In rural areas, private fee-for-service plans still have  
2 room to operate between low county fee-for-service rates and  
3 the national average, which can be substantially higher. In  
4 high fee-for-service urban counties, they may be plans that  
5 bid way below current benchmarks and were able to offer  
6 attractive, enhanced benefit but might be just below the new  
7 benchmark and can only offer minimal benefit enhancements  
8 under the national average alternative.

9 DR. MARK MILLER: If I could just say, because I  
10 want to reinforce this point, in particular. You look at  
11 something like that and you see, well, 90 percent. So,  
12 what's the problem? That could potentially be an option.  
13 But there could be plans in those areas but the extra  
14 benefits that they could offer would likely be very  
15 different than what they're currently doing. So, how many  
16 of them and how attractive they would be to beneficiaries  
17 over time would be a real question. Whereas, at the other  
18 end, the likelihood, meaning low-cost fee-for-service areas  
19 -- the likelihood of those plans would have much greater  
20 opportunity to offer extra benefits.

21 And so, over the long haul, what it does to plan  
22 distribution I think is not well represented by this

1 simulation.

2 DR. HARRISON: Now, this slide shows the  
3 percentage of beneficiaries who would not have a plan  
4 available under our simulation assumptions.

5 The second column shows the percentage of urban  
6 beneficiaries who would not have a plan in their county, and  
7 the third, the percentage of rural beneficiaries who would  
8 not have a plan. As we saw in last slide, 19 percent of  
9 beneficiaries would have no plans bidding below 100 percent  
10 of local fee-for-service. The effect of the 100 percent  
11 local fee-for-service alternative would be very different in  
12 urban and rural counties. Fifteen percent of beneficiaries  
13 in urban counties would have no plan bidding below the  
14 benchmark, compared with 31 percent of the beneficiaries in  
15 rural counties.

16 Now, because about 80 percent of rural  
17 beneficiaries are in counties with fee-for-service spending  
18 lower than the national average, rural benchmarks are higher  
19 when there is greater reliance on national average fee-for-  
20 service than on local fee-for-service spending levels.  
21 Also, the floor in rural counties is near the national  
22 average fee-for-service spending, so plans that are there

1 now are generally bidding below the national average.

2 Now, perhaps less intuitive is that beneficiaries  
3 in urban areas are also more likely to have plans available  
4 under the 100 percent national fee-for-service alternative.  
5 As it turns out, about 55 percent of urban beneficiaries are  
6 in counties with fee-for-service spending below the national  
7 average. So, we have kind of a skewed distribution where  
8 you have a few large urban counties that have much higher  
9 local fee-for-service spending.

10 Now, while the simulations suggests that fewer  
11 beneficiaries would have plans available under the 100  
12 percent local fee-for-service alternative than under the  
13 national fee-for-service and the blend alternatives, there  
14 are still some policy issues about the types of areas where  
15 plans would be encouraged. We might undercut plans in high  
16 fee-for-service areas such as Miami-Dade County where they  
17 have the potential to be efficient for the Medicare program.  
18 At the same time, we may encourage plans to enter low fee-  
19 for-service areas, such as Marathon County, Wisconsin, where  
20 fee-for-service may be the most efficient way to provide  
21 Medicare benefits.

22 On this slide, we have the current benchmarks, the

1 100 percent local fee-for-service figure, and an approximate  
2 national fee-for-service figure. There are about 80 plans  
3 in Miami-Dade that are bidding far enough below fee-for-  
4 service to save Medicare money on their enrollees. If  
5 Miami's benchmark was set to the national average, \$720 in  
6 this example, we would probably force out a plan that bid,  
7 say, \$800 per member per month, even though that plan would  
8 cost the Medicare program significantly less than the cost  
9 of keeping a beneficiary in fee-for-service in Miami.

10 At the same time, we would encourage plans in  
11 Marathon that bid \$650 a month, even though that plan would  
12 cost Medicare significantly more than covering the Marathon  
13 beneficiary in fee-for-service Medicare.

14 Let me briefly summarize the findings from the  
15 simulations. First, a caveat, again, about the simulation  
16 assumption: We assume that a plan would be available if  
17 bids below the alternative benchmark -- I'm sorry, that  
18 plans would be available if a plan bids below the new  
19 benchmark, and unavailable if it bids above. In reality, if  
20 a plan knows it would be bidding above the benchmark it  
21 could one, withdraw; two, stay and charge a premium; or  
22 three, shave costs and bid lower. So, more plans might be

1 available than our simulations show in some cases.

2           At the same time, if a plan is only bidding  
3 slightly below the alternative benchmark, it might decide it  
4 cannot be competitive with fee-for-service Medicare, and  
5 then it would withdraw. This would be especially true if it  
6 did not have much enrollment in the area. So, in some  
7 cases, our simulations are likely to overstate plan  
8 availability. That being said, it is safe to say that all  
9 alternatives reduce average benchmarks to 100 percent of  
10 fee-for-service spending and result in lower spending and in  
11 reduced plan availability.

12           Of all the alternatives, 100 percent local fee-  
13 for-service benchmarks have the most impact on availability,  
14 and the 100 percent national average fee-for-service average  
15 benchmark, the least. The different alternatives may have  
16 different effects on urban and rural areas, as we've shown,  
17 and alternatives other than the 100 percent local fee-for-  
18 service option would continue to encourage the entry of  
19 inefficient plans in some areas.

20           Now I'm seeking guidance for further work. I'd  
21 like to know what other simulations you would like to see.  
22 We can show you results by plan type and we can use our

1 larger payment areas instead of counties, but we will need  
2 to make some planned behavioral assumptions in situations  
3 when a plan has submitted bids for some but not all of the  
4 counties in a payment area.

5 I'd also like to know whether there is other  
6 metrics other than availability you would like us to  
7 simulate.

8 Another question is, should we simulate some  
9 formulations that use plan bids to set the benchmarks? This  
10 would require us to make some behavioral assumptions because  
11 plans usually submit multi-county bids and we need a way to  
12 determine how those bid should be translated into single-  
13 county bids that would be needed to set the new benchmarks.  
14 And are there other alternative formulations you'd like to  
15 see, such as hybrids?

16 Also, if we are to make any recommendations, we  
17 might want to lay out our goals for the MA payment system  
18 and for the Medicare Advantage program, in general. What  
19 should the goals for the program be? Should payment policy  
20 ensure that all beneficiaries can have a choice of plans?  
21 What trade-offs should we make between ensuring plan  
22 availability and how much we have to pay for that

1 availability? And can we use payment policy to encourage  
2 improved quality in Medicare? And are there any other  
3 things?

4 Thank you and I look forward to the discussion.

5 MR. HACKBARTH: Thanks, Scott. Could I kick off  
6 round one with a clarification question about slide 10.

7 I can't quite wrap my mind around this and the  
8 Minneapolis-Miami comparison, so you would you say one more  
9 time what --

10 DR. HARRISON: Okay. So, what we're doing is  
11 we're taking a constant, a national number; in this case it  
12 was \$720. And we then adjust that for the GPCIs and for the  
13 area wage index, and that's it; that's the new benchmark.

14 It turns out that --

15 MR. HACKBARTH: So, normally what we hear in the  
16 Minneapolis to Miami comparison is that, if you put them on  
17 a level playing field in terms of pricing and use a national  
18 standard pricing -- so basically, what you are comparing is  
19 utilization rates between the two. Minneapolis is much  
20 lower than Miami.

21 DR. HARRISON: Right.

22 MR. HACKBARTH: This is doing something very



1 different.

2 DR. HARRISON: Well, what this does is everything  
3 except the utilization, and that's why they're the same, and  
4 all the difference you see is utilization.

5 MR. HACKBARTH: Yes.

6 MR. EBELER: The payment would be the same, but  
7 Miami being far to the right on the x axis shows that their  
8 current costs are much, much higher.

9 MR. HACKBARTH: Yes. Right.

10 MR. BERTKO: But Scott, if -- I know this is  
11 probably not risk adjusted for the population in this  
12 particular diagram. The people in Miami, by many risk  
13 adjustment measures, look to be sicker. I'll use those  
14 verbs.

15 DR. HARRISON: I think that's right.

16 DR. REISCHAUER: So, this isn't the 1.0 person?

17 DR. HARRISON: Well, the local fee-for-service  
18 spending is for the risk of the population. Actually, this  
19 should be risk-adjusted.

20 DR. MARK MILLER: Yes, I thought the answer to the  
21 question --

22 DR. HARRISON: Yes, this should be risk-adjusted.

1 DR. MARK MILLER: -- this is Miami on the  
2 utilization -- because of utilization is to the right, risk-  
3 adjusted.

4 DR. HARRISON: Correct. Actually, the horizontal  
5 values wouldn't be risk-adjusted. This is just the national  
6 rates.

7 DR. MARK MILLER: Right, but those are payments.  
8 Those are payments.

9 DR. HARRISON: That's right.

10 MR. HACKBARTH: Let me see hands for a first round  
11 of clarifying questions.

12 MR. GEORGE MILLER: Thank you, Glenn. Excellent  
13 report.

14 In the text of the report, you talked about  
15 disenrollment and the impact and -- I didn't see any  
16 discussion about the impact of disenrollment on plans one  
17 way or the other. Can you eliminate or clarify if  
18 disenrollment has any impact on the plans and how we can --

19 DR. HARRISON: I'm sorry for the confusion.

20 MR. GEORGE MILLER: That's okay. So,  
21 disenrollment --

22 DR. HARRISON: The report isn't what we're talking

1 about today, even though it is for you to review, but we  
2 were done presenting on the report chapter, but we will  
3 catch up with you after on that.

4 MR. GEORGE MILLER: All right. That would be  
5 fine, then. Okay.

6 MR. BERTKO: Scott, just to confirm that this is  
7 modeling -- represents an ultimate, steady-state, new  
8 payment system, not any of the glide path part in between  
9 now and then.

10 DR. HARRISON: Correct.

11 MR. HACKBARTH: Let me see hands for round two  
12 comments or questions.

13 DR. REISCHAUER: I think this is great, Scott. As  
14 you say, the real question is, would plans, even though  
15 their bids are a little bit below, come forth with an offer  
16 that is attractive to the population.

17 I was wondering if we were going to do something  
18 like look at enrollment in plans, now, as a function of  
19 where they are relative to the benchmark, the bid versus the  
20 benchmark; they're just volume and then get some kind of  
21 idea about how big a gap, either dollar or percent, you need  
22 to make an attractive offering. And you could do this by

1 the type, like HMO versus PPO versus private fee-for-service  
2 and do this, and then you could get a better feel for the  
3 answer to your question, which you say you can't answer at  
4 all, which is, would all of them disappear, because the gap  
5 between the suggested new benchmark and what their bids are  
6 is only 2 percent or something, and we don't see any  
7 significant enrollment in those kinds of situations now.

8 DR. HARRISON: Yes, we can do that.

9 MR. BERTKO: A comment first, and this is just to  
10 reinforce comments that Scott and Mark made, and Bob, you  
11 were kind alluding to here, is the benefit changes that  
12 would come with this would be massive. And so, there would  
13 be some large amount of disruption in the way people think  
14 of things.

15 So, what Scott has presented to us, if I'm, again,  
16 interpreting it right is, what to the current bids look like  
17 and how would they survive if the bidding process and  
18 mechanisms went along the same way?

19 The question, I guess, and the suggestion for  
20 further work would be, could we look also at some mechanism  
21 which uses bids, Scott used the word hybrid, or otherwise,  
22 that would bring in planned bids to help set those.

1           So, rather than, for example, having some  
2 arbitrary amount, and I would take the, I think, last of  
3 your modeling there, the 75/25 bid, and use instead either  
4 reliance on a median bid, reliance on some other mechanism,  
5 a combination of the local fee-for-service rates or  
6 otherwise and see what that would do. Its main advantage,  
7 in my mind, is that it recognizes what each plan has to pay  
8 and recognizes the local patterns of care there.

9           Miami clearly has too much demand and too much  
10 utilization, and some of the plans have done a pretty good  
11 job reducing it; others have not made that great  
12 consequence.

13           The last comment is also an observation. Scott,  
14 when you talked about using the national average you  
15 referred to Part D. My main comment there would be, unlike  
16 part A and B services, Part D services where you buy drugs  
17 can be generally bought on a national basis. So, if you're  
18 buying an antihistamine, you can buy it for the same cost  
19 effectively everywhere in the United States, whereas both  
20 hospital and physician services, particularly hospital  
21 services, vary dramatically around the country. So, using a  
22 single national number, even with modest adjustments for

1 price inputs, is difficult, let's say.

2 MR. HACKBARTH: The other difference there -- I  
3 agree with that point, John. The other difference between  
4 Part D and this is that Part D, the only choices available  
5 are private plans that are participating under this system.  
6 In Medicare Advantage, you have people choosing between  
7 traditional Medicare and private plans, with traditional  
8 Medicare having a dramatically different cost structure,  
9 which is the policy problem we're grappling with. So, to  
10 draw the analogy to Part D just isn't apt to me. It's a  
11 different kind of choice that beneficiaries face.

12 DR. HARRISON: And there's also only 26 payment  
13 areas or something.

14 MR. HACKBARTH: Yes. On the first question or  
15 comment about bidding, we had an exchange about this, I  
16 think, after the last meeting.

17 I had actually interpreted statutory mandate as  
18 asking us to look at using bids as an option, because it  
19 refers specifically to looking at the relationship between  
20 plan costs and Medicare fee-for-service payment levels. I  
21 sort of leap to the conclusion that one of the options that  
22 thought we ought to look at is using bids as part of the

1 payment process.

2           And you saw it differently. You don't think that  
3 is one the options we were asked to look at. Would you just  
4 elaborate on that?

5           DR. HARRISON: I wouldn't say that I didn't think  
6 -- I wasn't sure whether we were supposed to use bids  
7 specifically. I definitely think it's an option and we  
8 could do it, but it will require you to trust the staff on  
9 the assumptions pretty broadly.

10           DR. MARK MILLER: Actually, if I could say  
11 something about this.

12           Decidedly, what the legislation said is you should  
13 use the bids to represent cost, and then it went on with  
14 language, and we were interpreting that as kind of the blend  
15 option.

16           Now, we actually have been working on bid types of  
17 strategies here. Given the limitations of our simulations  
18 and what we can do, exactly what they tell you gets kind of  
19 us squirrely. What we can do with you and with whomever  
20 else -- because it could get pretty hairy, the conversation,  
21 we can give you a better sense of what those real  
22 limitations are. But we're not completely tone deaf; We've

1 actually been messing around with this and some of the  
2 limitations of what you can say with a bid-based benefit are  
3 even more -- in my opinion -- even more limited than what  
4 you see here. And so, we can get you to that point.

5 DR. CHERNEW: I think this is wonderful. I think  
6 it's crucial to do this by plan types, absolutely crucial.

7 It's not clear to me whether more or less  
8 availability is good or bad by different types of plans and  
9 a bunch of things, and so, I think it's absolutely essential  
10 to do it by plan types.

11 Second, I think it's important that we do it by  
12 plan types.

13 Third, plan types are important.

14 And fourth, larger payment areas are less  
15 important than plan types, which are important.

16 [Laughter.]

17 DR. CHERNEW: Fifth is, you asked about other  
18 metrics you -- -- I'm interested in the magnitude of the  
19 difference from where the existing benchmarks, more so than  
20 just, is it above or below, or what it is. Because I think  
21 the magnitude of the difference tells me about how much the  
22 benefits are going to, much more so than when you were still



1 there and what you were doing.

2           So, if I had to pick, the first thing I'd look at  
3 -- I'd want to know how many counties -- sort of the  
4 distribution of the payment, relative to what they were.

5           I won't say much -- I was going to say a lot more  
6 about this benchmark by bids. I think the summary of what I  
7 just heard, and what I would have said for it is, you need a  
8 lot more behavioral and econometric analysis to be able to  
9 say anything about that scenario, and I would be skeptical  
10 of you spending a lot of time trying to do it in a way that  
11 later people will be skeptical of how you've done it.

12           So, although I think that's a wonderful way to do  
13 it, I would want to have a lot longer conversation about how  
14 that was done before sending you off to figure out what  
15 would happen if we did it by bids, because you need to  
16 figure out the plans are going to bid, how they are going to  
17 respond, what's going to happen. That's a very, very, very  
18 difficult thing to do, although maybe a decent policy  
19 option, but I would have to think through all the literature  
20 about how to do that.

21           I'll stop there -- actually, the last thing on  
22 just a general point, the current system has two features

1 which explicitly are not in here, which I just think you  
2 should be clear that they're not in here.

3 One of them is, they tend to say that your update  
4 is based on where you are now plus some update factor, so as  
5 opposed to that, it's just going to be 100 percent fee-for-  
6 service. It's more like, you have what you have now, plus  
7 the increase in what fee-for-service was, right?

8 In the current system, when they have five things  
9 like this, it works as a ratchet. You get the higher of  
10 blah, blah, blah, blah, blah. The way you've done this and  
11 the way it should be done is a little more absolute and a  
12 little more less ratcheting. I think that's the way you  
13 have done it, but because that's a different way than the  
14 current system, I think it's worth emphasizing that you  
15 didn't do it that way.

16 Plan type. Thank you.

17 MR. EBELER: First on, off of this chart, the red  
18 line is a conceptual -- we know it points up and to the  
19 right, but I think it would be useful at some point to know  
20 the real shape of that line. It presumably isn't a constant  
21 slope, county by county.

22 DR. HARRISON: Do you mean the yellow line?

1           MR. EBELER: No, the fee-for-service line, the 100  
2 percent fee-for-service line.

3           DR. HARRISON: It's just a construction.

4           MR. EBELER: No, I know that. I'm just saying the  
5 real shape of that line would help us think about the  
6 implications of some of these options.

7           If you then switch to slide 17, I'm not sure  
8 Michael was clear enough. I would argue that we need plan  
9 types in this analysis. I do think looking at our standard  
10 -- MedPAC has a preexisting recommendation about moving to  
11 larger payment areas. I think it would be useful to look at  
12 that.

13           I think the other metrics is where we get into --  
14 explicitly into the goal slide. I don't think the number of  
15 plans available is the goal. It strikes me that the metric  
16 one wants to look at is, are we attracting plans of the type  
17 that can change delivery and quality and service in the  
18 areas that are amenable to that change without getting --  
19 without attracting on the other end a whole bunch of plans  
20 that can't improve things in areas where fee-for-service  
21 might be cheaper. That's the trade-off you're trying to  
22 see, but it's sort of getting the right plans to the places

1 where there's opportunities strikes me as the thing we're  
2 trying to do here. So that's what I would suggest as a  
3 metric.

4           The other alternative is something -- I don't know  
5 if, Scott, you mentioned it, or Mark had mentioned it -- but  
6 we had discussed at one point in the past, and there's all  
7 sorts of blends we can have here, but talking about a  
8 payment at the fee-for-service level in whatever the payment  
9 area we define, in the middle, for most places and defining  
10 a sort of a high and low point. There is a point where you  
11 would have a blend off of that, and at the high end, you  
12 would start coming down. But it's something to think about.

13           DR. HARRISON: You'd want to see that plan  
14 availability if we were to do something like that?

15           MR. EBELER: Again, we're going to be suggesting a  
16 set of analyses that are going to be impossible to do, but  
17 yes. So, that would be my walk through page 17.

18           MR. HACKBARTH: I agree the plan type is better  
19 than plan availability, but the reality is that plan types  
20 cover a wide array of different organizations. What counts  
21 is a coordinated care plan -- is really a wide spectrum of  
22 different organizations, a big range from Kaiser Permanente

1 to an IPA-type HMO that's basically discounted fee-for-  
2 service and contracts with, more or less, every provider in  
3 a market. They would show up as the same broad plan type,  
4 but their ability to do what you referred to, actually  
5 change patterns of care in a way that Medicare cannot, is  
6 very different. So, even plan type has its problems.

7 DR. DEAN: I, too, would thank you for the  
8 presentation. It's been a confusing area, and I think it is  
9 gradually becoming a little more clear.

10 I would say that we really need probably to step  
11 back, for me, at least, and go to page 18 because I don't  
12 know that we can answer any of these questions unless we  
13 really try to decide where we're going.

14 It seems to me that, originally, MA was introduced  
15 with the idea that if you brought private entities into the  
16 process, you would get innovation and cost saving. But  
17 then, we began to hear that there was unhappiness because it  
18 wasn't available in certain areas and it wasn't uniformly --  
19 a beneficiary didn't have access to these kinds of things,  
20 and so, there were a variety of things done to increase the  
21 access. And then, there was the issue that, well, maybe it  
22 ought to be a mechanism to enhance Medicare benefits, and

1 certainly there is some appeal to that.

2 I think the whole thing has gotten very confused  
3 and, in fact, which of these mechanisms we try to proceed  
4 with depends very heavily on where we are trying to get to.  
5 And so, I don't know who makes that decision, whether we  
6 make that recommendation or whether that's something that  
7 Congress has to do or whatever, but it seems to me that we  
8 can't make any decisions about the mechanisms or what plan  
9 type works the best until we try to decide what our goals  
10 are, because I know that specifically the models that have  
11 certainly been most efficient in terms of controlling costs  
12 and efficiency are never going to be available in my area.

13 I mean, if you have a closed-panel HMO, they  
14 simply aren't going to be in central South Dakota, and  
15 that's just the way it is. I mean, we accept that; that's  
16 the reality, but we need to recognize that. We can't, I  
17 think, try to drum up the rules to force them into that area  
18 by paying them some exorbitant amount of money, that's not  
19 efficient for anybody.

20 Like I said. I think we really need to focus on  
21 what the goals are and get those clear before we try to make  
22 these other decisions.

1           MR. HACKBARTH: I agree with that, Tom, and I have  
2 some thoughts when we get through the queue.

3           DR. CROSSON: A couple of thoughts with respect on  
4 the last two pages, which are the questions that we've been  
5 asked to answer.

6           One novel idea is I would like to see the  
7 information displayed by plan type.

8           [Laughter]

9           DR. CROSSON: And to make it a little bit more  
10 complicated, taking off on what Glenn said, is it possible  
11 within the HMO plan type to develop distinctions based on  
12 the predominant delivery system? That would be one  
13 question. You don't need to answer that right now.

14           But we ought to look at plan type both with  
15 respect to the issue of ultimate availability as well as the  
16 financial impact on various types of plans.

17           I particularly would like to see it in the context  
18 of the option that's on page 10, which I'm still not quite  
19 sure I fully understand, but which looks like it has perhaps  
20 some more -- I don't know what -- flexibility than some of  
21 the other models. There might be more to it than I can see,  
22 but I'd like to understand it better.

1           With respect to the goals of the MA program, as  
2 Tom said, you sort of want to start with what you're trying  
3 to do and then work on the details. So, when Scott gave the  
4 presentation, he said the original purpose of the MA plan  
5 was to promote choice of delivery systems, and I think it  
6 was, actually, because, for example, for our own program --  
7 and we were active at the time in talking about this issue,  
8 we couldn't see how an organization that provided full  
9 prospective payment to its delivery system was going to  
10 function well in a fee-for-service environment.

11           And so, the ability to have pre-payment blended  
12 very well with our basic business plan and philosophy and  
13 has proven to be valuable. And I think it has expanded to  
14 other similar types of organizations.

15           Is the situation the same now or is it different?  
16 Well, in some ways, for us, it's the same, in other ways, I  
17 think it's different. We've talked here at the Commission a  
18 lot about delivery system reform and the fact that there  
19 appears to be a relationship over time between the structure  
20 of the delivery system and how it's paid, and at least  
21 potential to achieve cost savings. So, I would posit, just  
22 for an answer to the question, that, at least as I think



1 about it going forward, the goal of the Medicare Advantage  
2 program -- one goal, one important goal -- is to support  
3 methods of prospective payment to delivery systems that have  
4 the potential, anyway, to increase quality and to increase  
5 efficiency, particularly through the use of preventive  
6 medicine, early detection of disease, and care coordination  
7 of patients with chronic disease. There may be others but  
8 to me that is one core goal of the future Medicare Advantage  
9 program.

10 DR. MARK MILLER: Nancy had to catch a plane and  
11 if I don't have this right we'll just deal with it off-line  
12 with her.

13 I think what she was saying in terms of the impact  
14 analysis, can we also judge, when we look at plan  
15 availability, how many beneficiaries are affected. So, it  
16 may be 16 percent of plans but how many beneficiaries are  
17 accounted for by the numbers of plans rather than just...

18 DR. REISCHAUER: In the chart showing you how many  
19 would have zero plans, one plan, two or more, what she  
20 wanted to know was the enrollment in those areas. So, as  
21 you pointed out these would be much, much smaller numbers of  
22 people would be affected by having zero plans in their area,

1 maybe.

2 DR. HARRISON: Right. This was weighted by people  
3 living there as opposed to people enrolled. Right.

4 DR. SCANLON: My comments relate to plan type,  
5 too, as well as the objectives. And it partly goes back to  
6 what Jack said in terms of the idea that there may be some  
7 benefit from coordination of care that's coming from the  
8 plan that is positive for both the program and the  
9 beneficiary. I think my comment comes into a series of  
10 questions.

11 The first one would be, as you pointed out, Glenn,  
12 there are plans that accomplish that and then there are  
13 plans that nominally coordinate care, and they don't, okay?  
14 So, the question is, can we actually identify and set  
15 standards for accountability to know that we got the kind of  
16 coordination that we would desire, because if not, I don't  
17 want to just open up a benefit for pseudo-coordination.

18 The second issue for me is, what is the cost of  
19 providing that kind of coordination? Because yes, there may  
20 be savings as one of the program benefits, but my suspicion  
21 is that the cost is very much through -- very great  
22 economies of scale related to the cost of doing this. They

1 are not just scale economies in terms of the number of  
2 people that you have in the plan which larger payment areas  
3 might be able to deal with. I think it goes to density,  
4 because you've got to be involved. If we took all of South  
5 Dakota as the payment area, it's a big deal to coordinate  
6 across all of South Dakota.

7           So, there's this question of, well, what's the  
8 relationship, the production function for the plan in order  
9 to provide this coordination, and should the payment policy  
10 reflect that?

11           The next question would be, is there a price which  
12 we would not be willing to pay to bring this kind of  
13 coordination to any locale because it just becomes too  
14 expensive? But if we value this service and think of it as  
15 of benefit to beneficiaries as well as to the program, and  
16 this goes back to our discussion in 2005, there may be  
17 circumstances where we are willing to pay more than  
18 traditional Medicare because we're getting something more  
19 than traditional Medicare, and we're going to, on average,  
20 either break even or save the program money because there is  
21 going to be other areas where the density of the population  
22 and the savings that were going to get -- Miami being the

1 case that is always cited -- are going to be so great that  
2 we're going to be able to subsidize this activity somewhere  
3 else. So it's a series of, kind of, ifs.

4 MS. HANSEN: Thank you. The areas really relate  
5 to the goals of the program, and since Arnie isn't here, one  
6 of the things he would always say is the highest value and  
7 quality for the least price. So, it seems to be kind of a  
8 factor of that. And hopefully have appropriate -- whatever  
9 that would be -- on program spending.

10 But my bulk of thoughts really centered around  
11 what Jay and Bill just said relative to, whatever the plan  
12 types are, is the ability to think of the big trunks of  
13 prevention, early detection, and management and effective  
14 chronic disease and excellent episodic care in that process?  
15 So it really defines delivery system and care coordination  
16 in that sense.

17 So, at this stage, the plan types and the  
18 relationship -- and this goes back to the chapter, in  
19 reading that, and I don't know whether this is the metric  
20 side yet -- it is more of a descriptive side of the  
21 relationship of the philosophy and alignment between the  
22 plan and the physician groups that oftentimes arranged that.

1 So, it may not be just the staff models, but are there other  
2 models that have been in practice now that produces some of  
3 the outcomes that we are looking for in terms of the  
4 ultimate beneficiary receiving prevention, early detection,  
5 effective chronic care management, and excellent acute  
6 management with this coordination?

7           So, I just wonder, to be agnostic about it for the  
8 moment, are there any indications of how best to take a look  
9 at possible settings that aren't huge, integrated systems  
10 that can still score well on these results? So, it is more  
11 of a, as they say, a much more descriptive side, but  
12 implicit in it is, does the beneficiary get the best front-  
13 end care, secondary prevention, and tertiary care? That  
14 should be, hopefully, to me, the ultimate outcome of using  
15 the Medicare funds appropriately and having the -- pay the  
16 least amount of money for the best result.

17           I think, related to just looking at the  
18 trajectory, how do we take a look at unique areas like South  
19 Dakota, when you have a very desperate environment where  
20 it's spread out?

21           As a sidebar, I know that our minor but still  
22 available PACE program is now in a demonstration project of

1 rural settings with capitated systems and that kind of  
2 environment. So, more is coming, but how can you do that in  
3 much more dispersed environments with a capitation approach?  
4 What does the delivery option look like? So, I know that is  
5 actually in process right now and so I just offer that.

6           Again, we always talk about the scale issue, and I  
7 well respect that, but right now that principal is looked at  
8 when you have spread-out populations but the ability to  
9 align philosophy and service.

10           So, just some thoughts to look at more on a kind  
11 of context background rather than -- we're certainly not  
12 ready for matrix yet.

13           MR. HACKBARTH: I want to pick up on this  
14 discussion of goals, and I agree emphatically with the  
15 statement that Tom and others have since seconded about the  
16 need to be clear about what our goals are.

17           I've been involved with this program and its  
18 predecessors as an academic advocate of the idea, a  
19 government official arguing for the legislation, the TEFRA  
20 legislation, '82, HCFA -- a government official implementing  
21 the program, a plan executive, a physician group executive -  
22 - I've seen this from a lot of different angles, and what

1 strikes me about the history of this is that, in fact, the  
2 goals have migrated over time in an unspoken way.

3           Initially, the goal, as Jay described, was to  
4 create an opportunity for different organization types to  
5 serve Medicare beneficiaries. And because the payment level  
6 was set at 95 percent of Medicare's cost, they had to do so  
7 in a way that was efficient. So, as a way to get out of the  
8 fee-for-service model, use different organizational and  
9 payment types in the name of achieving lower cost and more  
10 efficient delivery of care.

11           Over time, in subtle ways, the goal has migrated.  
12 We then went into a period where the focus became much more  
13 on, well, we've got to alter the goal to achieve geographic  
14 equity. And that meant a couple different things.

15           One was we want equal opportunity for  
16 beneficiaries in all areas of the country to get added  
17 benefits.

18           And second, and related, was the notion that we  
19 shouldn't be punished in Minneapolis for our efficiency and  
20 traditional Medicare, and not have the opportunity under  
21 Medicare Advantage and its predecessors to get more benefits  
22 for our constituents in those areas. So, geographic

1 equities started to become really important.

2           Then, that's migrated relatively recently to,  
3 well, what we're going to use as our metric is plan  
4 availability. We got to the point where we're counting  
5 plans. Is there a plan in every part of the country? How  
6 many plans are there? And it is total disregard for what  
7 the plan type is, what their capabilities are. It's just,  
8 are they out there, and then we've got to pay them enough to  
9 produce added benefits to have geographic equity. And so,  
10 what was a very focused idea about importing innovation into  
11 the Medicare program has morphed into, well, let's throw  
12 money at it until we can have enough plans everywhere that  
13 offer lots of benefits. That migration of the goals is  
14 really a problem, and it's always been a problem, but, boy,  
15 today, more than ever, it's a problem.

16           Now, we're about to see the leading edge of the  
17 baby boom generation retire with attendant financial  
18 stresses on the government and Medicare and we've got  
19 trillions of dollars of new federal obligations that we're  
20 assuming. We've got to get back closer to the original  
21 objectives for this program. So, that's speech number one.

22           Number two is that I support many of the ideas



1 about innovative delivery that can produce better value.  
2 The question is, well, how do we tell which organizations  
3 can do that? I don't think you can do it by looking at plan  
4 type documents or program brochures. You've got to assess  
5 it by looking at the data. Do they produce costs that are  
6 lower than traditional Medicare? Do they produce added of  
7 quality, improvements in quality, above what is the ambient  
8 in their community?

9           Because of the fiscal situation, I'd like to see  
10 us say traditional Medicare is the objective. If you can do  
11 it for less, by all means, come in; we want your help. But  
12 I'd be willing to say we're willing to pay more if you can  
13 demonstrate higher quality than exists in that community  
14 without your involvement. We will pay more for it. I don't  
15 care what your type is, but if you can improve quality  
16 compared to what exists ambient in that community, I'm  
17 willing to pay more for it. But we are not even close to  
18 those objectives.

19           So, I would like to see a sharp statement of re-  
20 focused objectives inform the payment option discussion as  
21 opposed to just producing tables on plan availability of  
22 different payment models. I think that's a really essential

1 for a good a policy discussion.

2 DR. CHERNEW: First, let me say I agree with that  
3 completely and there is a distinction between the marching  
4 orders to Scott about how you'd like to see analysis like  
5 this, in which case I think you have to work off of things  
6 like plan type, and the broader policy comments that I think  
7 you made, which I agree with completely.

8 The two things I wanted to say were, first, care  
9 coordination stuff, which I think is very important, has  
10 become a bit of a buzzword, and I do think it's an important  
11 part of the value added of health plans, but there are many  
12 other ways in which health plans can be innovative and add  
13 value, including refining payment mechanisms and a whole  
14 bunch of other things. So, I think when we think about when  
15 we look at plans and what we want to do, it's not just we  
16 want to have a bunch that coordinate care and do those  
17 things better, plans that can do a more efficient job by  
18 adopting better payment mechanisms or more efficient payment  
19 or better physician intervention things, better networks.  
20 If there was a plan that could come in and have a more  
21 narrow network and focus on physicians who we thought were  
22 really good, that would be a fine added value, even if they

1 weren't doing some of these other things. So I think we  
2 have to recognize there are important ways plans can add  
3 value, not just through coordination.

4           The second point is, and something that I think is  
5 important in the system is, if we had plans that were  
6 innovative and good in a range of ways, there's an advantage  
7 to the people who are never in that system. And I think we  
8 sometimes talk about someone who's choosing to be in, say,  
9 the traditional Medicare system or have the choice to be in  
10 another system, but because these systems are operating in  
11 the same places, often, then interact. And I think an  
12 important side benefit of supporting the Medicare Advantage  
13 program or the Medicare health plan program more generally  
14 is the efficiencies that potentially can be gained by the  
15 health care system overall if -- and this is a big if -- if  
16 one can encourage the development and diffusion of plans  
17 that are doing good things for the markets where they are,  
18 and I do think there are some of those.

19           MR. HACKBARTH: Other comments?

20           Let me just go to page 15, Scott. I haven't  
21 really studied this, but I think I understand the basic  
22 point here and I think it's an important one.

1           One of the concerns that I've had about the broad  
2 concept of, well, let's get to 100 percent of fee-for-  
3 service on a national basis by lowering the payments in some  
4 of the high-cost areas like Miami and increasing the  
5 payments in some of the areas where Medicare costs are low,  
6 and just average it out, is the dynamic effect of that.  
7 What is the signal that you're sending? And I worry if you  
8 cut the payments too much in Miami, and I'm guarded about  
9 this, because I think they can be cut somewhat without  
10 dramatically reducing plan participation and enrollment.  
11 But if you just whack and say, we're going to the national  
12 average, I think what you run is the risk that we will  
13 discourage plans in the areas where they can most make a  
14 difference and create lots of private fee-for-service plans  
15 in areas of the country where they don't do anything to  
16 promote care.

17           We could in theory have national 100 percent of  
18 fee-for-service expenditures, but our signal as to what we  
19 want to buy is just totally wrong and we're going to end up  
20 with a program that is worse than useless, because just  
21 think of what's going to happen in all those rural areas of  
22 America where we are encouraging everybody to enroll in

1 private fee-for-service. Basically, we will undermine  
2 traditional Medicare and its payment systems. Over time,  
3 more and more people will migrate into add-no-value private  
4 fee-for-service plans, and Medicare's ability to set rates  
5 and do the things that it does will just disappear; it will  
6 be undermined.

7           So, just getting to 100 percent of fee-for-service  
8 on a national basis is a very simplistic idea.

9           Conceptually, I can embrace it, but how you execute it makes  
10 a huge, huge difference in terms of the dynamic effects.

11           Any other questions or comments on this?

12           DR. REISCHAUER: If we wanted to go back to the  
13 future, you could think of stimulating something on the  
14 order of a national fee-for-service except in areas where  
15 local fee-for-service is higher than the national, and then  
16 95 percent or 90 percent of local, because you want to some  
17 kind of incentive to generate the behaviors that you're  
18 suggesting.

19           DR. STUART: Just a quick observation. You  
20 mentioned this, but I think we may have lost track of it as  
21 we've gone through the discussion, and that is that these  
22 simulations are based only on the standard MA plans, the

1 coordinated care plans, and the standard fee-for-service  
2 plans. They include the SNPs and it excludes the employer-  
3 based plans. These are two beyond the traditional private  
4 fee-for-service plans, which are the fastest growing.

5           So, I think that, when you conduct these  
6 simulations, it's also, I think, imperative that we say,  
7 well, we're not doing simulations in these other areas. As  
8 many people have suggested here, you really do get into  
9 those behavioral implications of what these rate structure  
10 differences are going to have. It might well be that it  
11 would be -- people then would -- the migration into SNPs and  
12 employer-based plans would be even greater in order to avoid  
13 taking a cut in terms of pay, depending on where you are.

14           MR. BUTLER: One quick comment. I understand your  
15 last point about the whacking too much. And then, on the  
16 other hand, in the meantime, the private fee-for-service  
17 plans are growing rapidly and providing a lot of new  
18 benefits to people. It's going to be kind of hard to pull  
19 those back and retract and the stability for them.

20           So, short of a moratorium, I don't how you put the  
21 brakes on putting more of these things out there that are  
22 going to be hard to unwind. We ought to think about that.

1           MR. HACKBARTH: Well, of course, there was an  
2 effort to make the terms less favorable to private fee-for-  
3 service in the last go around.

4           I don't know, Scott, if you have any comment on  
5 the likely magnitude of that effect?

6           DR. HARRISON: Remember now, what they did is, in  
7 2011, you really can't have a private fee-for-service plan  
8 in areas where there are networked plans. So, it will  
9 change the dynamic quite a bit. Whether they are able to  
10 come up with -- I mean, if they come up with networks, then  
11 they are really not private fee-for-service anymore so...

12          MR. HACKBARTH: But this goes back to the previous  
13 discussion. They are not, in terms of our existing legal  
14 category, statutory categories. But is a plan that  
15 basically contracts with everybody using the Medicare rate  
16 structure -- just says, well, I'll give you 5 percent more  
17 than the Medicare rates if you sign my contract, and it goes  
18 to everybody in the community. And because the payment  
19 levels are so high, they may have the ability to fund that  
20 higher payment level out. So now, they've got everybody in  
21 the community funded by taxpayer dollars and higher  
22 payments. Are they really any different in terms of their

1 ability to coordinate care and produce higher value for  
2 Medicare beneficiaries and the taxpayers? They are not.  
3 They have just taken taxpayer dollars and paid providers  
4 more than traditional fee-for-service.

5 Okay, I think we're done.

6 We now have our public comment period.

7 Just as a reminder, the ground rules are please  
8 identify yourself and your organization, and limit your  
9 comments to no more than two minutes. When the red light  
10 comes back on please finish your comments.

11 Thank you.

12 MS. CARLSON: Good morning. I'm Eileen Carlson  
13 with the American Nurses Association.

14 These comments are with regards to the hospice  
15 benefit. It's very troubling that the discussions regarding  
16 length of stay seem to occur without any reference  
17 whatsoever to quality of care and patient outcomes. There  
18 appears to be an underlying assumption, possibly  
19 presumption, that increasing lengths of stay in hospice care  
20 necessitate a cutback in hospice benefits and I think that  
21 assumption needs to be acknowledged and re-examined.

22 As recognized by some Commissioners, hospice care



1 presents a unique circumstance whereby high quality of care  
2 can directly result in the lengthening of a patient stay  
3 beyond what was anticipated, and this is generally a  
4 successful outcome for the patient.

5           There's also widespread recognition within the  
6 health care community of the difficulty, sometimes  
7 impossibility, of precisely predicting or projecting how  
8 long a terminally ill patient will live.

9           There's also widespread recognition that hospice  
10 care is significantly less costly than acute care and offers  
11 many additional benefits for the patient and the family.

12           Consequently, I would urge MedPAC to include  
13 quality of care as an element in examining hospice care  
14 length of stay and recognize that a longer stay can  
15 demonstrate a successful outcome and a result of high  
16 quality of care.

17           Moreover, the question needs to be examined of  
18 whether decreasing payments over length of stay may serve as  
19 a disincentive to maintain a high quality of care across a  
20 patient's entire length of stay.

21           Thank you.

22           MS. KASSON: Hello, I'm Caroline Kasson. I'm the

1 President and CEO of the National Hospice Work Group and I  
2 want to comment on the hospice discussion that we just had.

3 As a hospice provider CEO since 1981, before there  
4 was Medicare reimbursement, I want to first of all thank you  
5 for taking up hospice in the intensive and complex way that  
6 you have done.

7 But I wanted to take the opportunity to comment on  
8 -- I believe it was Commissioner Butler's -- suggestion that  
9 hospice was a social contract with Americans. And I hope  
10 that you will continue to explore that. And I hope that you  
11 will continue to look at how complicated that contract is in  
12 this country, and why some of the other things that were  
13 discussed in that comment period still aren't not happening,  
14 why hospice is only caring for about 40 percent to 50  
15 percent of the patients, and how misaligned incentives  
16 throughout the rest of the health care system really have a  
17 great deal to do with some of the issues that you're taking  
18 up and continue to look at that.

19 So I encourage you and I hope you'll work with the  
20 provider community to begin to explore some of those things  
21 and help you understand, at least from our perspective, how  
22 that works.

1           So I want you to know that we appreciate the work  
2 that you've done, that for the most part I believe the  
3 providers are very supportive of looking at payment reform.  
4 They are extremely supportive, the hospices that I work with  
5 on a daily basis, are extremely interested in accountability  
6 and very, very eager to ensure that all hospices have high  
7 accountability standards.

8           We are also happy that we're going to get more  
9 data that will help you and all of us understand the work  
10 that goes on at the patient's bedside.

11           As you do your work, I think the most interesting  
12 thing about perhaps what you do and what we do is that this  
13 is the one system that you will take a personal interest in  
14 over the next 20 or 30 or 40 years, because you are creating  
15 the system that you and your loved ones will be a part of.

16           So thank you very much.

17           MS. WILBUR: Hi, I'm Valerie Wilber with the  
18 National Health Policy Group and the Special Needs Plan  
19 Alliance. I want to follow up on a comment that was made by  
20 one of the Commissioners about the exclusion of SNPs and  
21 some other models from this analysis.

22           I think it's really important that SNPs, PACE, and

1 other programs that potentially are going to be affected by  
2 changes in payment system are taken into account, and I  
3 haven't heard anything about SNPs or PACE or private  
4 fee-for-service being excluded from the type of changes that  
5 Congress has looked at when they've talked about going back  
6 to 100 percent fee-for-service.

7           So I understand the reason for excluding it in  
8 this analysis, because they aren't universally available.  
9 But certainly for special needs plans they are widely  
10 available across the country and I would encourage MedPAC to  
11 see if they could include them in the analysis.

12           The other thing I would like to follow up on is I  
13 really agree with the widespread support for looking at  
14 types of plans in terms of delivery systems and the type of  
15 benefits offered and such. Special needs plans have a whole  
16 new set of requirements, as you know, under MIPPA which  
17 include a wide range of additional care management  
18 requirements in terms of having individualized care plans,  
19 annual assessments of functional, psychosocial, health risk  
20 and individualized care plans for everybody enrolled in the  
21 plan.

22           So I think the fact that SNPs have to develop

1 these models of care when they submit their application  
2 gives a lot of information to CMS about the types of models  
3 of care that are being developed that would provide sort of  
4 a database for being able to look at these models of care in  
5 relation to outcomes and then looking at them in relation to  
6 the payment systems being suggested.

7           And then the last thing I would suggest is, in  
8 addition to looking at types of plan and models of care,  
9 that you look at patient populations being served by these  
10 programs in terms on the adequacy of the current payment  
11 mechanism because there have been a number of studies  
12 published or underway by groups such as the University of  
13 Rochester in New York, Millaman has done work, Redden and  
14 Anderson has done work, and Hopkins is about to publish a  
15 study that indicates that certain populations, whether it's  
16 new enrollees, people with frailty, people with multiple  
17 comorbidities, and plans that serve exclusively populations  
18 that have sustained high cost over long periods of time are  
19 underpaid in relation to fee-for-service by the current HCC  
20 system.

21           So rather than having sort of a blanket  
22 across-the-board reduction of MA plans in relation to

1 fee-for-service, I think it's really important for MedPAC to  
2 spend some time looking at which populations served  
3 exclusively by some of these alternative plans may currently  
4 be being paid less than regular MA plans as you think about  
5 how to adjust payment.

6 Thank you very much.

7 MR. HACKBARTH: Okay, we're adjourned. Thank you.

8 [Whereupon, at 12:03 p.m., the meeting was  
9 adjourned.]

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