

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 22, 2004
10:09 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

***April 23rd proceedings begin on page 229**

	2
AGENDA	PAGE
Implementation of the Medicare drug benefit -- Joan Sokolovsky	3
State approaches to implementation of the Medicare drug benefit -- Jack Hoadley, NORC	13
Defining long-term care hospitals -- Sally Kaplan, Carol Carter	51
Public comment	102
Beneficiaries' financial resources and financial liability -- Dan Zabinski	110
Dual eligible beneficiaries -- Anne Mutti, Susanne Seagrave, Sarah Lowery	131
Purchasing strategies -- Kevin Hayes, Anne Mutti, Jill Bernstein	146
Characteristics of independent diagnostic testing facilities and ambulatory surgical centers -- Ariel Winter	160
Hospice care in Medicare: Recent trends and a review of the issues -- Cristina Boccuti, Sarah Thomas	179
Chronic kidney disease and chronic care improvement programs: A case study -- Nancy Ray; Chris Hogan, Direct Research, LLC	204

Note: April 23rd proceedings begin on page 229

1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning, everybody.
3 Welcome to those of you in the audience. This is the last
4 meeting in this annual cycle of MedPAC. Much of the
5 material that is presented and discussed today will appear
6 in the June report, but not all of it.

7 In keeping with how we've handled June reports
8 in the past, or at least most of them, much of the
9 material in the June report is educational in nature, some
10 of it foreshadows future MedPAC discussions and
11 recommendations. There will be only one chapter in the
12 June report that actually includes recommendations and
13 that is one on long-term care hospitals, and there will be
14 commissioner votes on that.

15 DR. SOKOLOVSKY: What I'm going to present for
16 you today is what will be the second half of a June
17 chapter that focuses on implementation of the Medicare
18 drug benefit. This is about the processes that have to be
19 gone through when people change drug plans or drug plans
20 enter or exit markets.

21 Whether Medicare beneficiaries choose drug
22 coverage through Medicare Advantage plans or stand-alone
23 drug plans, their drug plan is very likely to be managed
24 through a pharmacy benefit manager or PBM. PBMs currently

1 manage drug benefits for about 200 million Americans,
2 processing 70 percent of all prescriptions dispensed
3 annually.

4 The form of this chapter is to look at what
5 happens when a transition takes place, what are the
6 processes that have to be gone through, what are the
7 problems that arise, and what are the implications for
8 implementation of the Medicare drug benefit. To maximize
9 efficiency and cost savings, the Medicare drug benefit
10 depends upon competition among plans. The challenge for
11 the program is to provide opportunities for continued
12 competition while minimizing instability and disruption
13 for beneficiaries.

14 There are two kinds of changes that we're
15 dealing with here. One where a plan exits a market and
16 all of its enrollees must change drug plans. And the
17 second, when individuals change plans during the annual
18 open seasons. Although some of the issues are different
19 in both cases, whether plans enter and exit the market, or
20 beneficiaries enroll and switch plans, plan sponsors and
21 the Medicare program will have to ensure that the
22 transition from management of the drug benefit by one PBM
23 to another PBM is as seamless as possible.

24 The process of making drug plan transitions is

1 one that there's virtually no research on but a great deal
2 of anecdotal reports of the difficulties involved. Our
3 study tried to provide some research on it. We focused on
4 the experiences of plan sponsors that changed PBMs to see
5 what issues they encountered and what were some of the
6 best practices that minimized problems. Our goal was to
7 see what policy lessons could be learned.

8 It was a three-part study that began with
9 structured interviews with experts who had experience with
10 drug benefit management. Our interviewees included
11 representatives from PBMs, pharmacists, consultants with
12 experience managing these kinds of transitions,
13 representatives from health plans, and other large
14 organizations that have recently changed PBMs. These
15 experts not only gave us their experience but also
16 recommended sites for us to visit. In the second part of
17 a study we conducted two site visits, one at a large
18 public organization and one large private organization
19 that had both recently changed PBMs. At these sites we
20 met with benefit managers and other executives that were
21 involved in the decision to change PBMs. We met with
22 physicians and pharmacists, union officials, and external
23 consultants employed by the organization to help manage
24 the transition process. Finally, at each site we

1 conducted two focus groups, one with active employees and
2 one with retirees where they gave us the sense of what
3 their experience was during the transition.

4 So first I'd like to give you some idea of the
5 process. The first question you would ask is, why does an
6 organization make the change? The most frequent answer
7 was cost. They thought that they could get better cost
8 savings from another PBM. They weren't satisfied with the
9 cost savings they were getting from their current PBM.
10 Some of our interviewees also mentioned service problems.

11 It was a very hard decision to make to change
12 PBMs because everybody agreed that it was a very time-
13 consuming and resource-consuming process. Universally we
14 heard that to do it well it takes at least six months.
15 One plan we heard from did it in 90 days but had
16 continuing and what they considered very major problems.

17 Once they make the decision to change they tend
18 to issue an RFP asking for proposals from PBMs about how
19 much they would charge and what they would do, et cetera.
20 At this point, if the benefit is going to change, and by
21 change it usually means higher copays, stricter
22 formularies or some change that enrollees might not like,
23 some plans would begin the communication process at that
24 time trying to explain why they're going to have to make

1 this change.

2 Once the new plan is chosen, this is when the
3 data transfers have to take place. There are two kinds of
4 data transfers. One is the data from one PBM to another.
5 This would include who's enrolled, all the enrollment
6 information. It includes if people are on maintenance
7 medications and they have open refills where the physician
8 has written a prescription for say a hypertension drug
9 that can be continually renewed before the person has a
10 come back to the physician, that open refill information
11 has been transferred from one PBM to another.

12 This information and also the new benefit
13 structure, what copays will be charged, what is the
14 current formulary, what is the deductible, all have to be
15 electronically available at the pharmacies on the day that
16 the new plan takes over, usually January 1st.

17 The new plan has to issue cards that the
18 enrollee can take to the pharmacy on that day to process a
19 prescription. And all of the plans emphasized that it's
20 important to have this data in advance so you can test the
21 data transfers and whatever bugs are in the system they
22 can be fixed.

23 Lastly, you have to provide notice to
24 enrollees, but also to pharmacists, and if possible

1 physicians. They say that the earlier you can do it, the
2 better.

3 When we look at the problems there is one piece
4 of very good news that comes out on top which is that in
5 general transfers of the big data sets from one PBM to
6 another are much easier now than they used to be, much
7 more streamlined because plans are using standardized code
8 systems. But that doesn't mean that problems don't occur,
9 and when they occur, for example, if enrollment data isn't
10 transferred or the new cards are not received by the
11 enrollee before the date of the transfer when they go to
12 the pharmacy they cannot get their medication. This is
13 particularly a problem if the open refills, those
14 maintenance medication prescriptions are not transferred
15 because in that case, even if the beneficiary is willing
16 to pay cash out of pocket, the pharmacist cannot legally
17 dispense the medication because there's no prescription.

18 Sometimes incorrect copayment amounts are
19 transferred, but the biggest problem that we heard from
20 virtually all of our interviewees was the issue of prior
21 authorizations. Prior authorization is when a plan asks
22 the physician to get approval in advance for dispensing a
23 particular medication. It could be because it's a very
24 expensive medications like one of those new self-

1 injectable biotech drugs that can be very, very expensive.
2 It could be for a drug that's subject to overuse like some
3 of the painkillers that people may become addicted to. It
4 also can be a situation where a drug is not on the
5 formulary but the patient has already gotten an exception
6 because the drug that's on the formulary doesn't work for
7 them.

8 In all of these cases plans had a great deal of
9 trouble getting that information transferred from one plan
10 to another.

11 When it doesn't work it frequently entails extra
12 physician visits. Sometimes if it's a whole plan and
13 people are using the same physicians -- we had one case
14 where physicians had to rewrite every prescription for
15 every kind of open refill and every prior authorization
16 that they had issued.

17 One example where it did work was one plan that
18 thought about this very carefully in advance and actually
19 sent to every enrollee a separate list with other drugs
20 that would require prior authorization. They were the
21 only plan that never reported any problems on this issue.

22 Even with the best communication strategies we
23 found that many times the first time that enrollees and
24 physicians were aware that the formulary had changed with

1 the new benefit was when the patient arrived at the
2 pharmacy counter. This is something we'll talk about a
3 bit later.

4 Another problem that we heard about were changes
5 in mail-order procedures. This was a case where a plan
6 would use a different mail order system than the previous
7 plan, the drugs would look different and the beneficiaries
8 would get drugs, usually generic drugs. The old ones
9 might have been blue. This is a different company; it's
10 red, and they're not sure that they're getting the right
11 medication anymore.

12 It's clear that some of these problems are
13 easily and quickly dealt with them. Some of that seem to
14 take much longer.

15 So what are the implications for the Medicare
16 drug benefit? I'm sure it's going to come as a surprise
17 to nobody to say that an effective communication strategy
18 is critical. Everybody said, you've got to tell people
19 lots of times, you've got to tell them simply, and you've
20 got to tell them in different ways. Send them a letter,
21 send them e-mail, have advertisements, do a lot of
22 different things because no one thing will reach
23 everybody.

24 Second thing was time. Again this was something

1 that came up everywhere. You need time to test the data
2 transfers and prepare targeted mailings to people who are
3 going to be affected. For Medicare there's a tension
4 between giving plans enough time to develop their bids and
5 negotiate with CMS and making sure that there's enough
6 time for beneficiaries to learn about their choices, and
7 on the other hand, giving plans the time to transfer the
8 required information.

9 Data transfers will be much more complicated for
10 Medicare because the plan will have to have systems in
11 place at the pharmacy where they can track copay levels by
12 income, and also the level of out-of-pocket spending.
13 Plans right now -- PBMs have told us that right now they
14 don't systems in place that can track the level of
15 individual spending at the pharmacy counter, although some
16 of them can do it through their own mail-order systems.

17 There also, we think, should be contract
18 requirements that plans have procedures in place not only
19 how are they going to get the data from the old PBM when
20 they get new enrollees, but also what are the requirements
21 for handling data when enrollees leave the plans. We
22 found that there were situations where the old PBM, not
23 many, but a couple where the old PBM left on a bad note
24 and transferred no information. We think that Medicare --

1 that it would be important to put in the contract, make
2 sure that doesn't happen.

3 Lastly, we think it's important to provide
4 information in advance to pharmacists and physicians. It
5 seems that no matter how good the communication strategy
6 is many people will first learn about the changes from the
7 pharmacist or their physician. Making sure that they have
8 this information well in advance is important because they
9 will be doing much of the problem-solving and education
10 anyway.

11 It may be hard, on the other hand, to notify
12 physicians because it won't be clear necessarily to the
13 new plan who would be the relevant physician to notify.

14 As I said before, this study, along with what
15 you heard in the March meeting on formularies will be part
16 of a June chapter on implementation of the drug benefit.
17 Jack Hoadley, who is sitting next to me here, is the head
18 of a team of researchers at Georgetown University and NORC
19 at the University of Chicago and they've been working with
20 us on a set of implementation issues. Jack is going to
21 present to you now our preliminary results from a study on
22 state roles in implementing the low-income drug benefit.
23 This won't be part of the June report but will be a later
24 study. We will continue monitoring and looking at

1 implementation issues of the drug benefit.

2 Now I want to turn it over to Jack.

3 DR. HOADLEY: Thank you. Appreciate this
4 opportunity to talk about the results of our work. Want
5 to first just review quickly the low-income provisions
6 that we're talking about when we talk to state folks and
7 some other people in this project. We really talked to
8 them both about the discount card program and the eventual
9 Part D benefit. As you certainly know, the discount card
10 is very much in real time right now, so as we did our
11 interviews we really were seeing a moving target as we
12 talked to people. Card sponsors were selected in March.
13 Beneficiary enrollment will start in a few weeks and the
14 cards will generally be effective in June.

15 As you know, beneficiaries can select one
16 Medicare-sponsored card which normally would have an
17 enrollment fee of no more than \$30, but in the case of the
18 low-income beneficiaries or at least those whose incomes
19 are below 135 percent of poverty and are not in Medicaid
20 or some other drug coverage, they'll be eligible for
21 transitional assistance of \$600 for each of the two years
22 of this program as well as waiving that enrollment fee.

23 we turn to the Part D benefit in January 2006,
24 low-income beneficiaries -- all beneficiaries that want to

1 participate in the benefit will need to select a Part D
2 plan, and that includes the beneficiaries who are
3 currently on Medicaid. So again, that's one of the areas
4 where the states are affected by this. Low-income
5 beneficiaries, as I'm sure you know, are subsidized.
6 While the details of the subsidy are complicated,
7 generally those up to 150 percent of poverty or Medicaid
8 enrolled get some portion of a subsidy. And then states
9 can supplement coverage for any beneficiaries but can't
10 get federal match for that supplementation. So these are
11 some of the context items that affect the folks that were
12 talking to us.

13 Basically we're mostly dealing with the topics
14 of education and outreach and there really are three goals
15 that need to occur. One is the need to explain the
16 changes in prescription drug coverage to beneficiaries.
17 Another is finding and enrolling individuals who are
18 eligible, particularly for the low-income benefits, the
19 transitional assistance for the discount cards or low-
20 income subsidies for the Part D benefit. Finally, the
21 potential to provide help to Medicare beneficiaries in
22 assessing their options and choosing among the different
23 discount cards right now or the prescription drug plans
24 later.

1 So our project was to interview a number of
2 experts in this area, particularly state officials and
3 others knowledgeable about the issues facing the states
4 and their interactions with low-income beneficiaries to
5 find out how states are perceiving their role, what are
6 they doing now and what do they plan to do as they look
7 forward to 2006, and what are some of the challenges they
8 face. We conducted a total of 19 telephone interviews
9 with mostly current and former state officials, a few
10 other policy experts and advocates for low-income
11 beneficiaries. We covered a total of 13 states amongst
12 our various interviews, and as you see, we covered
13 different kinds of programs within the states.

14 I put the dates very precisely here. We
15 conducted our interviews between March 10th and April 14,
16 so we really were straddling a number of the key events,
17 particularly the announcement of the discount card
18 sponsors and some of the other things relating to that.
19 So our messages to some degree changed as it went along.

20 So first I'll talk about the discount card
21 portion. What is it that states perceive as their roles
22 and responsibilities? In many cases the first thing they
23 told us is that they perceive this to be a federal
24 responsibility and not really a state issue. One of the

1 quotes was, when it's a federal program we think the feds
2 will do the communication. These are Medicare folks, why
3 should we have to do anything?

4 Now obviously their message became more nuanced
5 and different as we went along but there really was often
6 the first message we heard is, why has this become our
7 problem? We didn't pass this new program and it's a lot
8 of new work for us. Some of that's about funding, but a
9 lot of it is about really trying to figure out and learn
10 about a program that the federal government is operating
11 and they're only trying to keep up and learn what's going
12 on.

13 States also vary a lot in their capacity and
14 their interest and their enthusiasm for dealing with these
15 issues. For example, the SHIP programs, the health
16 insurance counseling programs vary a lot across states.
17 Some have are very active, very effective programs that
18 really give them a big base to build on. Other states
19 have much smaller programs, ones that don't have nearly
20 the kind of experience and capacity to do the kind of work
21 that's potentially here to be done.

22 States also varying incentives, and one
23 particular important area for that is the state pharmacy
24 assistance programs. Those states that have pharmacy

1 assistance programs, particularly now when we're talking
2 about the discount card, they have a very strong incentive
3 because if their enrollees are eligible for and can
4 enrollee in the transitional assistance, that's \$600 that
5 the federal government will pick up of the drug cost that
6 the state funds don't have to pay for. So they have a
7 strong incentive and we'll come back to that point in a
8 minute.

9 Just to elaborate on that, I think again people
10 are probably familiar with the state pharmacy assistance
11 programs, but there are 19 or 20 operating programs around
12 the states, another six or eight that are authorized but
13 not operating. Most of these are fully state funded
14 although some are operating with federal dollars under
15 waivers. The programs vary a lot. There's a handful of
16 large, long-established programs like New York, New
17 Jersey, Pennsylvania, Illinois. Other states they're
18 smaller just because they're small states but still are
19 long-running active programs, and then some others that
20 are relatively small and/or relatively new. So depending
21 on the different situations in those states again what we
22 heard from them was often different.

23 So what is it states are doing about the
24 discount cards? A few of them by the time to talked to

1 them had begun to do some kind of outreach. In some cases
2 though they said, this is still early. One told us, we're
3 still trying to figure out what this piece of legislation
4 is, understand all its elements so we can coordinate
5 within the apartment. That's kind of where everybody is
6 at this point. But things are starting to move and we
7 really actually saw the pace pick up across the month or
8 so of our interviews. We heard about one SHIP program
9 that was already holding sessions during the month of
10 April to tell beneficiaries in their state what to expect,
11 even though they couldn't yet counsel them specifically
12 about how to go about picking one card versus another.

13 We saw the state action more so in the states
14 that had either active SHIP programs or active pharmacy
15 assistance programs, again where the incentives greater.
16 We saw a lot less when we talked to Medicaid folks.
17 Generally because Medicaid beneficiaries are not eligible
18 for the discount cards the Medicaid folks said this really
19 isn't our issue for this part. We'll be involved in the
20 drug benefit in a year or so, but not right now.

21 The planning really is going on very vigorously
22 on the discount card program and that's something if I'd
23 talked to you after our first handful of interviews I
24 wouldn't have said. But as we moved we could really see

1 that pace picking up. Yet at the same time they're also
2 waiting to see what CMS is going to tell them about the
3 various issues and what about the federal money that's
4 going to come through to assist the counseling.

5 So what is a typical state plan for outreach?
6 In many cases they rely on Medicare. They've been told
7 that Medicare will send a letter to all beneficiaries,
8 that the Social Security Administration will send a
9 targeted letter to all low-income beneficiaries who might
10 be eligible for transitional assistance. Card sponsors
11 will soon be reaching out as well. Then what the states
12 figures that they can do, at least the ones who seem to be
13 more interested and active in doing this, is to provide
14 follow up messages, to have letters that follow the
15 federal letters and give them more information specific to
16 the situation to might apply in that state.

17 In particular, again, that has to do with the
18 states with strong SHIP programs who are training
19 volunteers and preparing to do one-on-one counseling,
20 which is one of the strengths of the SHIP programs.
21 They're really expecting to sit down with those
22 beneficiaries who come to them and try to help them figure
23 out whether to get a card and if so what card. But also
24 the states with pharmacy assistance programs are really

1 gearing up. Some have issued RFPs to designate a
2 particular card sponsor. Some have already sent out
3 letters to begin to tell people what to do. In some cases
4 the first message is, don't get a card until you hear more
5 from us. Then they'll have another mailing or other
6 communication going out to say, here's the way we think
7 you can take advantage of this program.

8 States are also beginning, and just this week
9 CMS, or at the end of last week, CMS announced some
10 options for auto-enrollment and standardized enrollment
11 forms that states could use, and the states are really, at
12 least the more active ones, are really prepared to start
13 doing that. Again, Medicaid agencies, they're just really
14 not seeing this as a big part of what they're doing.

15 What are some of the communication strategies?
16 Again, mailings are part of it. But they did point out to
17 us that mailings can sometimes raise more problems because
18 they raised questions, and they've got to be geared up to
19 be able to have a hotline or a phone line to follow up on
20 the questions that come up in the mailings. They've had
21 that experience with some of the mailings that went out on
22 the Medicare savings program in previous years and if they
23 weren't geared up and ready for the onslaught of calls
24 that followed then it actually became a burden to them.

1 They're also looking where they have existing
2 mailings going out to beneficiaries where they can add a
3 message about the discount card. One state told us that
4 they were interested in trying to communicate with
5 providers, to physicians, to pharmacists and would use the
6 periodic letters that go out through Medicaid or through
7 the state pharmacy assistance programs to add messages
8 about the discount card. Also do the same thing on the
9 web sites that they use to communicate with providers. So
10 you really get this variety of strategies.

11 What are some of the challenges that states will
12 face? Administrative capacity is certainly one. The
13 challenges of coordinating efforts across the different
14 state agencies that are involved, coordinating between
15 Medicaid and an aging department, coordinating within the
16 subagencies of an aging department. We heard a lot about,
17 especially when you're operating in a short timeframe, how
18 hard it is to bring all the relevant parties together and
19 get them all on the same message. There's the potential
20 for competing messages coming from CMS, from the states,
21 from the card sponsors and they're all trying to work hard
22 to try to make sure that doesn't happen. But when you're
23 working on this short timeframe, it's difficult.

24 Also challenges around reaching some of the most

1 vulnerable populations, the disabled, the
2 institutionalized, the frail elderly at home or in
3 assisted living. Most states acknowledge that those are
4 hard audiences to reach and at this point and this fast
5 pace they don't really have magic bullet strategies to how
6 to reach out, although some have tried to, in the past,
7 develop particular targeted communication approaches for
8 those.

9 Let's turn then to the drug benefit that goes
10 into effect in 2006. As we asked people about that our
11 first message was usually, again, a federal
12 responsibility. It's not our problem but we'll somehow
13 deal with it. But they really also gave us an equal
14 message that they did understand that this was a
15 population, particularly the ones who were enrolled in the
16 state programs like Medicaid and pharmacy assistance that
17 they felt a responsibility to. They understood that they
18 were part of the partnership that needed to make this
19 work. But that came after they first complained, we've
20 got this new job to do and it's not of our making.

21 What is it that states are doing relative to
22 Part D benefit in 2006? One person basically said, it's
23 still too early. That respondent told us that 2006 is a
24 millennium away in state time. We're just not there yet.

1 Somebody else said, there's nothing for anyone to do right
2 now. It's too soon. There's much that we're trying to
3 resolve with CMS. Until we have more information from the
4 federal government about what they are telling
5 beneficiaries, only then will we have a sense of how we
6 want to communicate and what the messages are we want to
7 communicate. So again their real message was, it's early
8 to figure what to do.

9 It's also that the circumstances are very
10 different. Again, Part D versus the discount card is a
11 different set of messages, and they're having to work hard
12 to absorb the messages for the discount card and it's
13 going to be different. So for example, you tell a
14 Medicaid beneficiary, right now the discount cards aren't
15 relevant to you. You have coverage through Medicaid. You
16 don't need the discount card. Next year they've got to
17 turn around and tell those same beneficiaries, now it's
18 Medicare Part D. You do have to be worried about this.
19 You need to enroll in Part D and need to select a plan.
20 So they're just beginning to learn really the split of the
21 messages that has to happen.

22 Same with the state pharmacy assistance
23 programs. Right now they're thinking about those that are
24 eligible for transitional assistance or ones we want to

1 get enrolled in that. They've got to also be now thinking
2 about how to create a wraparound, or if they want to
3 create a wraparound Medicare to decide what to do. So
4 outreach and education will only come after these policy
5 issues.

6 We even had one respondent say, I don't want to
7 get too far ahead because for all I know the federal
8 government will change the program again before 2006, and
9 it will look different by the time we're implementing it,
10 for whatever that's worth.

11 So what outreaches, again, will the states face
12 in 2006? It's really very similar to what they faced for
13 the discount card but it's more intensified because
14 there's a lot more to do. As I said, the messages will be
15 different. The messages need to go to all beneficiaries,
16 not just a smaller number that may find the discount card
17 relevant to their situation. But again there's a lot of
18 policy options. We don't know yet what the geographic
19 regions will look like, what there will be that focuses on
20 nursing home residents. A lot of the specific policy
21 issues that will effect how the states formulate messages
22 to do outreach and communication haven't been determined
23 yet.

24 Nursing home is a particularly interesting

1 question because obviously many, many nursing home
2 residents are Medicaid beneficiaries and the pharmacy
3 situation is different there. But it's really something
4 that we were told both by states and by, in one case, a
5 representative of the nursing home industry, it's just
6 something that's just early. We don't know yet how that's
7 going to work out but we know it's important and we know
8 we need to worry about it. Again, a challenge is going to
9 continue to be how to communicate with the various kinds
10 of vulnerable beneficiaries that states need to deal with.

11 Some what were our conclusions? First, that
12 outreach is critical in any kind of program where
13 participation is voluntary. States recognize that. They
14 know that they have a role in it, even if it is the
15 federal government's program and the feds started them
16 down this road. They know that they play an important
17 role to try to protect their states' residents.

18 They also tell us that the federal outreach is
19 tremendously important and that's where it's got to start.
20 And they know that if beneficiaries get messages from a
21 trusted source like Medicare or like the Social Security
22 Administration, that's something that is the starting
23 point for their understanding of the program.

24 States do understand that they can be important

1 partners in implementing the benefit and have, as we said,
2 on the discount card really started to take actions to be
3 partners and to be involved in helping on that. 2006 is a
4 millennium away for them and they just don't know yet what
5 they're going to need to do but they know they will do
6 something.

7 They also pointed out the role of not just the
8 SHIP programs that depend on volunteers from the community
9 but some of the community-based organizations that they
10 typically work in partnership with, whether it's advocacy
11 organizations, or senior centers, or other kinds of senior
12 and aging organizations. They know those groups are going
13 to be important as well as, and I didn't put it on this
14 slide, but the physicians and the pharmacists that people
15 turn to. That's one of the common points between the
16 findings that Joan was talking about and what we found
17 here.

18 Finally, anytime you talk about the states, we
19 know that the states' levels of investment, effective,
20 enthusiasm are going to vary considerably and it's going
21 to be affected by some of the differences that we've
22 talked about like whether or not they have a state
23 pharmacy assistance program, and the type of enrollment
24 and program that they had under their Medicaid.

1 So that's the end of my comments.

2 DR. NEWHOUSE: Thank you both for a set of
3 interesting and useful talks. I wondered, Joan, if there
4 was anything to be gained by looking at the experience of
5 changing fiscal intermediaries or carriers in terms of
6 handoff from one carrier to another? I don't know that
7 you need more material, but since you kept saying there
8 isn't really a lot of relevant information here I wondered
9 if there was anything there.

10 The second point I wanted to make is just a more
11 conceptual point, that some of the issues you are raising
12 would be alleviated if we had followed a path that was
13 more like the commercial model and one had a single plan
14 for a geographic area for a limited period of time and
15 then periodically re-bid it. That, it seemed to me would
16 not eliminate transitions or changes in formularies but it
17 probably would reduce some of the noise here.

18 DR. SOKOLOVSKY: As far as the fiscal
19 intermediaries and carriers, that's a wonderful idea and I
20 have to admit that never even occurred to me. I don't
21 think it could be part of the June chapter but it's
22 definitely something to look at.

23 MR. HACKBARTH: Isn't a more analogous situation
24 a transitional among private plans under Medicare

1 Advantage? Because part of the challenge here is that if
2 you're the new plan your new enrollee could come from any
3 number of different sources, each of which had different
4 formularies, different rules, as opposed to an employer
5 transition, the commercial model where everybody operated
6 under one set of rules and you've got to educate them
7 about a new set of rules. There are just more
8 permutations that you have to deal with under this
9 structure. The private plan situation under Medicare
10 seems like the most analogous situation to me.

11 DR. SOKOLOVSKY: Absolutely. On our formulary
12 project we did talk to a lot of plans that offer Medicare
13 Advantage and heard many of the same issues but because of
14 payment changes, generally speaking the drug benefit in
15 the past couple of years has been diminished enough that
16 these issues were much less.

17 MR. SMITH: Thank you, both. This was useful if
18 sobering. Joan, I was struck in the mailing materials by
19 two references, one is on page 12, one is on page 18.
20 They're not specifically important but they both suggested
21 that beneficiaries' price sensitivity led them not to take
22 drugs at all rather than to move to something in a lower
23 copay tier. That's striking and troubling and gets to a
24 lot of the questions that both of you raised about what

1 does the information look like, how do we communicate
2 people both about formulary structure but also about price
3 tiers in order to help people figure out where they ought
4 to go.

5 But it also raises the question of how will
6 people respond -- will people respond to closed
7 formularies that in some way limit their ability to take
8 the drug that their doc tells them to? Will they respond
9 the same way that the research suggests that they do on
10 the basis of higher tiered drugs that are prescribed?
11 That really does suggest that we need a mechanism to
12 tailor the communication almost one-on-one, which just
13 seems unbelievably daunting for a lot of the reasons,
14 Jack, that you identified. But there isn't some way to do
15 this on a broad basis, particularly if individuals respond
16 in the way that the research you cite suggests they do, by
17 not taking the drugs at all.

18 DR. SOKOLOVSKY: I don't know exactly what to
19 say. The research doesn't say that everybody will respond
20 that way, but there is a significant minority of people
21 who do respond that way, and I don't know the answer to
22 that problem.

23 DR. MILLER: Could I just say one thing about
24 this? I think there's two different issues here. One is

1 getting down to the retail level of dealing the patient.
2 I think when Joan was talking about how to communicate, be
3 sure that you're communicating with the pharmacist and the
4 physician, because some of that can happen there.

5 But then there's the second question of how
6 people respond to tiers, and there are some things
7 recently in the literature that raise the point that
8 you're making.

9 DR. REISCHAUER: Thank you, both, for
10 interesting presentations. Joan, I found your material
11 particularly interesting as someone who is considering
12 shifting the PBM of the organization that I run and its
13 affected my thinking about it.

14 I really wondered how much of this was relevant
15 to the Medicare situation. What you're talking about, the
16 employer market, is group and it's mandatory. I make a
17 decision that the Urban Institute employers are going to
18 go from one to another. This is individual and voluntary.
19 By voluntary what I mean is, somebody is in a plan --
20 we're talking about after the thing is up and running and
21 some of what you have is relevant to the getting it up and
22 running but not to the ongoing it strikes me.

23 So I'm an individual and I'm dissatisfied with
24 my current provider so immediately I've made some

1 decisions, I'm thinking about things, I'm looking at the
2 drugs that are covered here and aren't covered there and
3 how they're covered, or my daughter is doing it for me.
4 This is a very different kind of the situation from
5 suddenly I send all my staff a new little white card that
6 they have no idea really what has happened, and I've sent
7 them memos during the previous three months which they
8 have thrown in the wastebasket without reading or taken it
9 home and said to their spouse, you read this and he or she
10 has thrown it away. It's a very different kind of
11 situation.

12 Then secondly, I would assume, maybe
13 incorrectly, that CMS is going to specify a bunch of
14 handoff procedures. A minimum dataset that has to be
15 transferred from one company to another in a standardized
16 form and during open enrollment period there will be a
17 very routinized way of handling off this stuff. It's
18 going to be a problem, it strikes me, in two instances.
19 One is where in the middle of the year I move from Boston
20 to Arizona and I have to shift plans. My guess even there
21 is that, that judging from the discount card, that all of
22 these are going to be national plans, unless I'm in a
23 Medicare Advantage plan. These are going to offer
24 services everywhere.

1 The other possibility -- I see people shaking
2 their heads, but the other possibility is that a plan that
3 I signed up for leaves an area and therefore there's a big
4 group of people who have to -- but this is during open
5 enrollment -- shift. We can worry about that but I really
6 don't think these are going to be quite the same kinds of
7 problems that arise in the employer-sponsored environment.

8

9 Will there be dropped balls here and there?

10 Yes, but horrendous, I don't think.

11 DR. SOKOLOVSKY: I think what I want to say is,
12 yes, the model is different and I did try to reflect that
13 in the writing that some of these problems won't be the
14 same problems, won't occur. But I think that some of the
15 things we learned are, in some ways, exactly what you
16 mentioned. For example, one of the things we would like
17 to make sure when CMS comes out with its regulations is
18 that the handoffs are specified in the contracts, both for
19 old PBMs and for new PBMs.

20 The second thing we learned is that some of the
21 things are not routinized. Every plan has prior
22 authorizations. They don't have a way of transferring
23 smoothly that kind of data.

24 DR. REISCHAUER: But right now these are

1 cooperative relationships among private enterprises which
2 don't have to cooperate and one is snatching the other
3 guy's business. This is providing a service that's paid
4 for largely through government funds and I would presume
5 that the federal government is going to specify the
6 handoff of prior authorizations and existing
7 prescriptions. I would hope so.

8 DR. MILLER: I think that's the point, is we
9 wanted to point out the edges on the current system and I
10 think you've just put your finger on a couple places, the
11 open scripts, the pre-auth where under the current rules
12 those are handled on a retail basis. In this population
13 they may be a much bigger issue. You're right, it may be
14 that people at CMS will look at this and say, we've
15 already thought of this. But we wanted to make sure that
16 we walked through with the current state-of-the-art and
17 said, these are the places where things get rough.

18 I also think Joan's point about getting to the
19 physician and the pharmacist is something to emphasize in
20 the terms of the communication strategy, because I think a
21 lot of it will get hit there.

22 DR. REISCHAUER: Can't we be even stronger than
23 -- we're saying, in the private world these are problems,
24 and go the next step and say, in this new world

1 regulations and the way we write contracts can reduce
2 them.

3 DR. MILLER: I think that's the intention.

4 DR. REISCHAUER: Be stronger.

5 DR. SOKOLOVSKY: That is exactly where we were
6 going. I guess the other point to make is that in general
7 for individuals it may not be a problem but if drug plans,
8 as the years go on, enter and exit markets in the same
9 kind of history then you could see some more problems that
10 could be more similar to the employer problem where you
11 have a lot of people all at once. Again, it won't be as
12 simple where they all move to one other plan but you can
13 still have these large numbers of people who suddenly have
14 to make changes.

15 DR. HOADLEY: Can I just add a comment from
16 interviews that we did in conjunction with the transitions
17 project, that one of the points that a number of the
18 people mentioned when we got beyond just asking them about
19 their experiences in the private-sector transitions was to
20 ask them a little bit to reflect on what the differences
21 may be in the Medicare world. Obviously many of them are
22 familiar with what is coming. One of the big points that
23 they made is the difference between having an employer
24 who's watching over that process and making sure some of

1 these happen in group, who's the person that's going to
2 look over that process in an individual, one-to-one kind
3 of relationship?

4 Obviously part of that is what you were just
5 talking about in terms of CMS and I think you've got a
6 good point when you say that people are at least making an
7 active choice in many of these situations to change so
8 they're not just passive recipients, here's a card and a
9 memo. I didn't pay attention to it; now I'm in trouble,
10 so that will certainly help as well.

11 But there was certainly a lot of concern among
12 the folks that we interviewed that without the employer
13 benefits officer shepherding this process that it
14 potentially could be difficult and some of these steps
15 would be needed.

16 DR. NELSON: This is very good work and I want
17 to highlight just a couple of the aspects with respect to
18 access and quality, which after all remain a lot of our
19 concern in addition to the structural configuration and
20 exchange of information so forth that we've been
21 discussing. Every patient that has to change their
22 medication that has been successfully managing a chronic
23 problem like diabetes or heart disease, whatever, has the
24 potential both for hassle and harm. They've been doing

1 well; thank you very much, and now because of formulary
2 changes they have to have their medication program changed
3 and maybe it either doesn't work as well, or they have
4 side effects, or they believe that they have side effects
5 because of some of coincidental event. But in either
6 event it involves discomfort for the patient and hassle
7 for the physician, because you know who they are going to
8 talk to, their physician or their pharmacist.

9 You discussed grandfathering as a means of
10 minimizing that and I think that's an important concept to
11 show up in our recommendation, at least for certain
12 therapeutic classes or at least for certain periods of
13 time, understanding that some grandfathering may not be in
14 everybody's best interest, but certainly there has to be
15 the provision in order to minimize that problem.

16 The requirements for refills and prior
17 authorization should be made as a simple and hassle-free
18 as possible. Here again I'm concerned about access, and
19 for physicians, if this turns out to me an enormous
20 increase in the amount of hassle because of unrealistic
21 requirements for writing refills, getting prior
22 authorization, it would be one more incentive to not take
23 any new Medicare patients.

24 The formularies should be made available through

1 searchable electronic databases, either in a diskette or
2 that they can download from the Internet. Not all
3 physician office by any means have that kind of electronic
4 capability, but it's increasing and can be extremely
5 important assistance in keeping their knowledge of the
6 formulary up-to-date.

7 Some appeals process needs to be incorporated in
8 this, I believe. At least should be required of the PBMs
9 for uncommon but important drugs may not be on the
10 formulary just because they're used so uncommonly but are
11 important; some orphan drugs and that kind of thing.
12 There should be an appeals mechanism because it seems to
13 me that a Medicare patient's need for a certain drug ought
14 not to be ignored just because it's rare.

15 Finally, medical organizations and
16 pharmaceutical organizations, other professional
17 organizations, nursing and so forth, should be used in the
18 communication process. They all have communication
19 vehicles with their members. They probably will read
20 their journal more readily than they read their mail when
21 it's got government letterhead, so that opportunity ought
22 not to be missed. The same goes with AARP and the other
23 consumer groups with respect to the notification process.
24 Certainly we could consider having in our text some

1 acknowledgment of those opportunities.

2 MR. DURENBERGER: I found the chapter
3 challenging and very helpful to read. I sit here and
4 listen to people talk about Mary's mom and smile because I
5 am Mary's mom. I'm waiting for the influx of helpful
6 information, because I don't have an employer other than
7 the Federal Employee Health Benefit Plan to help me make
8 these decisions.

9 So my comments, like Glenn's and Bob's, are
10 directed to the chapter and the way the chapter is
11 constructed. And I really do believe that because the
12 chapter heading is so promising -- just look at that,
13 Implementation of the Medicare Drug Benefit. What follows
14 after that from our standpoint is really critically
15 important.

16 So laying it out right away in some longer range
17 context so we're really looking ahead to 2010 or whatever
18 the future may be, through a series of analytical steps
19 that we plan to take in order to advise the Congress on
20 the implementation of the program, to me would be a very
21 helpful way to construct the chapter and all of the
22 information that is contained in this chapter, which is
23 just like chapter one probably of a series of works that
24 we will be doing. And to keep in mind the importance to

1 whom this chapter is directed. Right now it ought to be
2 to 435 people who are the board of directors of the
3 Medicare program who are out there trying to defend
4 whatever they did without the benefit of anything like we
5 have, against the noise someone spoke of which comes
6 basically from two sources.

7 There are conflicting sources. Part of the
8 noise is simply coming from drug pricing itself. In my
9 part of the world -- and I've spoken to thousands of
10 seniors in the last few months in groups. In my part of
11 the world the pricing issue is way past the benefit issue
12 in terms of what is really important to them. It is
13 really obscuring the benefit issue. The only thing the
14 benefit decisionmaking, whether it's the discount card or
15 something else has going for it right now is the fear that
16 if you don't sign up now or you don't sign up
17 appropriately then you lose or you get a penalty or
18 something like that.

19 But the two areas I would suggest that our
20 trusted sources, one less than the other, the first is
21 whoever is out there selling it from the board of
22 directors better know what they're selling, and they had
23 better know where to refer people for information.

24 The second one is, the trusted source so far is

1 nobody that I have seen. It certainly is not SSA and it's
2 not Medicare and its not anything like that. It's the
3 doctor and the pharmacist, and I don't see a lot of
4 investment anywhere in informing -- and it's expensive to
5 do it -- to informing that part of the world that all of
6 us are going to rely on.

7 MR. MULLER: Both the chapter and your
8 presentations do a very good job, as the other
9 commissioners have mentioned, in laying out the challenges
10 of implementing it so it may be premature to think about
11 where one creates a safety net when some of the problems
12 arise. But my analogy, I think about the plans entering
13 and then exiting M+C and Medicare Advantage, the safety
14 net we've had over the last few years is in fact the
15 doctor and hospital network that keeps serving people even
16 when plans exit. I'd like to ask you to speculate a
17 little bit with us as to where those counterparts may be
18 in this program as plans come and go.

19 As the chapter that you presented to us as well
20 on information technology pointed out, probably the part
21 of the health care sphere that is most sophisticated in
22 its computerization is the pharmaceutical medical sector,
23 so probably instant eligibility determinations can be made
24 much more quickly in this arena than it can in other

1 benefit parts of the Medicare program. So the lack of
2 eligibility could be almost instantly ascertained when
3 plans exit as opposed to poster going on for a month or
4 two.

5 So what are your thoughts about where some
6 safety net might be as plans come and go? I know it's
7 somewhere down the line, but thinking about that safety
8 net I think is an appropriate thing for us to consider.

9 DR. SOKOLOVSKY: Are you talking about the
10 safety net for information or a safety net to provide
11 drugs?

12 MR. MULLER: A safety net for the beneficiary if
13 the old plan has pulled out and the new plan hasn't yet
14 made the successful communication, and contact, and sign
15 up, et cetera, with them. As you pointed out, going forth
16 now with 18 months of planning, which based on what you
17 said and what Nancy-Ann says, an incredibly tight
18 timetable, when people have to start doing it in 24 hours
19 or 24 days it gets even more difficult.

20 DR. SOKOLOVSKY: When those kinds of problems
21 happen it is going to be at the pharmacy that people are
22 going to find out that they have a problem, and it is
23 going to be the pharmacist who is likely to be the one who
24 is going to be trying to manage that. The pharmacist, who

1 cannot write prescriptions, is going to have to be in
2 contact with the physician, and that is in fact what
3 happens when there are problems in these private-sector
4 transitions now as well. There's a lot of additional work
5 for the pharmacist and for the physician.

6 MR. MULLER: But they're also pretty efficient
7 in saying, I can't help.

8 DR. SOKOLOVSKY: The ones that we spoke to spoke
9 about the kinds of works they did to help.

10 DR. NEWHOUSE: Ralph's scenario raises the
11 question about what happens if a plan pulls out and the
12 beneficiary hasn't signed up for a new plan, or finds that
13 out when they get to the pharmacy. Presumably they're not
14 covered. But then what happens next?

15 DR. SOKOLOVSKY: That's a really interesting
16 point. If a plan pulls out and the beneficiary doesn't
17 sign with someone else, it seems to me that's a whole
18 separate issue that really has to be explored, and I don't
19 know the answer offhand.

20 DR. NEWHOUSE: That's surely going to happen.

21 MR. FEEZOR: Joe, I wonder -- that actually was
22 going to be a part of my comment. First off, good
23 chapters. Joan, I found myself nodding. Everything that
24 you had in this chapter were things we confronted in

1 moving 400,000 lives in our self-funded program at
2 CalPERS.

3 Two points though. I think on the safety net
4 that Ralph is raising and the people who are lost, there's
5 not that employed. Okay, maybe the Secretary maybe could
6 be, but the reality is there's not that employer that has
7 that force. I wonder if the PBMs might not want to look
8 at the model that's used in some of the auto insurance
9 industry, the compulsory pools. Or maybe a better analogy
10 would be within the old days when every state had it's own
11 Blue Cross plan. They had an interplan bank, or a plan
12 would run that so if there was a lost soul, I show up and
13 my pharmacist says, wait a minute, I don't have you being
14 with Medco, and I say this is lifesaving. And the
15 pharmacy says, wait a minute, and there might be an
16 authority, if you will, as there are in some other
17 insurance, that that sort of account is marked against and
18 the losses in the administration of those lost individuals
19 then in fact gets borne by the entire participating
20 industry.

21 So I would suggest that we might explore that a
22 bit more in some of our subsequent evaluation.

23 The one other thing, it was in the chapter but
24 not as explicit as I thought on the lessons we learned.

1 If we learned anything in the last few years in
2 MedicareChoice was the constant changing of benefits
3 really began to cause people a lack of faith and their
4 willingness to participate. Here you probably can do some
5 tinkering on the benefits. And even more pernicious I
6 think can be the formulary changes that I can do every
7 month I guess. If I really am going to be suspect I could
8 probably even do some not so subtle risk and financial
9 impact play by what I'd do with that.

10 It is brought out in the chapter but I would
11 underscore it, I think you don't want to preclude
12 formulary changes but you want them to be done in a
13 predictable fashion with, as the chapter was excellent in
14 pointing out, with advanced notice to all parties. And it
15 might be that they're done -- if there are changes,
16 they're done at the beginning of a quarter or something
17 like that. I would even say once a year but maybe that's
18 too restrictive -- simply so that people get used to, wait
19 a minute, there may be some changes that affect me and I
20 know where to go to look to find it on the web site or
21 whatever.

22 DR. ROWE: Just a couple points. There's been a
23 lot of discussion about this. Very interesting stuff. I
24 do think there are already effective communications out

1 there. I visited my mother on Sunday. She's 94 and she
2 showed me a letter she got from Medicare describing the
3 discount drug program, the discount drug card. I thought
4 it was very well done. Now maybe I'm not the average
5 Medicare beneficiary, but she seemed to understand it and
6 it was very clear. So things are starting to happen
7 there. So we should give CMS some credit because we're
8 always beating on them. Obviously they are moving very
9 quickly here.

10 I wondered whether it was worth hearing a word
11 about what's going to happen to people in long-term care
12 facilities. I was thinking about Bob's comment about this
13 is an individual rather than a group. But the fact is
14 people who are in long-term care facilities get their
15 medications hand-poured by staff and they're purchased
16 right now probably by the nursing home or nursing home
17 chain or whatever through some wholesaler. Then the
18 individuals are probably charged some retail price per
19 pill I guess it varies.

20 Anyway here we are now, there's a nursing home
21 with 120 people and they're probably all Medicare
22 eligible, and the six different cards are being held.
23 What's going to happen and how are they going to get the
24 drugs? Or is the nursing home going to contract with one

1 company? These are not necessarily the beneficiaries that
2 the companies are going to be marketing to necessarily,
3 depending upon where the profit is. If it's a percent of
4 the total cost then they might be. So what's going to
5 happen there? I haven't heard much about that.

6 DR. SOKOLOVSKY: That was an issue that we were
7 particularly interested in and certainly it was part of
8 Jack's project to try to ask exactly those questions.
9 From states we heard very little information to begin
10 with. But there's some things in the law that we know.
11 One is the law says no copayments for beneficiaries in
12 nursing homes, and that was very important. It also says
13 that whoever offers a drug plan has to have a way of
14 coordinating with the pharmacies that provide drug
15 benefits within nursing homes. Exactly what that means is
16 not yet specified, but it is, as you said, an extremely
17 important issue.

18 DR. HOADLEY: I was just going to add, we did
19 try to explore that question with a couple of our
20 respondents. One of the respondents we had in our project
21 was somebody who formerly had worked in a state program
22 and now was working in a nursing home, company and then
23 others with some of the state people who interact a lot.
24 One of the things I was struck by again was this notion

1 that it really is early in the process. He said, in terms
2 of his own nursing home company that he is involved with,
3 they just haven't begun to think through that.

4 But what I did get a little speculation on was
5 the notion that one possibility is that a nursing home,
6 especially one whose residents are mostly on Medicaid,
7 that might be important, that might not be depending on
8 the circumstances. But one possibility is that they would
9 either ask the authorized representatives of these
10 residents or strongly recommended to them that they sign
11 up with a particular drug plan that has agreed to work
12 with nursing home pharmacy, because most of these nursing
13 homes as you're pointing out do have special relationships
14 with a particular pharmacy that orients itself and works
15 with nursing homes.

16 So I think what we'll probably end up seeing,
17 although quite how we get there is not so clear, is some
18 kind of situation where all the residents of a particular
19 nursing home end up getting signed up with a plan that
20 agrees to coordinate and work smoothly with that nursing
21 home. But of course you have got to do that in a way that
22 preserves the choice, the option of beneficiaries to make
23 their choice. It is a voluntary and it's voluntary what
24 plan you pick. It is early but I think it's a really

1 important area to pay attention to.

2 DR. ROWE: It's more like a group. If you think
3 about a nursing home change, maybe a big one, a national
4 one, then that's a big group. I'm a little concerned that
5 there are going to be some opportunities here that are not
6 going to be particularly advantageous to the Medicare
7 beneficiaries. I think that maybe half of the Medicare
8 beneficiaries in long-term care facilities have cognitive
9 impairment. We've got an enriched population that's
10 vulnerable because they're going to do what the nursing
11 home people suggest. Not that they would suggest a wrong
12 thing, but they're not quite as autonomous because of
13 their living situation and their cognitive status and
14 health care literacy. So we need a little bit of extra
15 attention to how that gets implemented.

16 MS. BURKE: Just in follow up to that, and I
17 apologize if you discussed this while I was out of the
18 room. What if any knowledge will we gain from the
19 discount card in answering some of these issues? That is,
20 how one either informs people or essentially gets that
21 information and also gets participation. Will we have
22 gained experienced or will that be transferable in any
23 sense in terms of our knowledge of what -- in the context
24 of nursing home patients but generally?

1 DR. SOKOLOVSKY: Funny you should ask that
2 question because as it happens, in this series of work
3 that we're doing with Georgetown and NORC the next project
4 is, what are the lessons that we're learning from the
5 discount card that will be applicable to Part D benefits,
6 and it's exactly those questions that we are looking at.

7 MS. BURKE: I'd like then, as Jack suggested, a
8 further discussion as we go along in terms of what we hear
9 in that context would be helpful.

10 DR. HOADLEY: One important thing to remember in
11 terms of particularly the nursing home population is for
12 those nursing home beneficiaries who on Medicaid, for the
13 most part the discount card isn't relevant. They won't be
14 involved with that. I think where we will get some things
15 to learn is that not all nursing home residents are on
16 Medicaid, so for those who are private pay or paid by some
17 other kind of long-term care insurance they may find the
18 discount card relevant and the whole process how that part
19 of it works certainly will be opportunities to learn.

20 DR. REISCHAUER: Just one comment on what I was
21 talking about before. My guess is that the transaction
22 costs for an individual for shifting from one drug plan to
23 another are going to be very high and people are going to
24 end up being very, very sticky. That's just how much of

1 this is going to go on.

2 But when you read the law lots of stuff isn't
3 specified, and as analysts you can sit down and think,
4 think of the loopholes, think if there's some evil force
5 here that really wants to turn a buck what they could do
6 to the elderly and what they could do to the industry and
7 all of that.

8 But if I had to predict three years out, I would
9 be very surprised if we saw a lot of pernicious activity.
10 My guess is that the folks who are going to be offering
11 stand-alone drug plans by and large are going to be
12 associated with large PBMs or insurers that have
13 reputations to maintain, that are providing a benefit that
14 is national not local. That there's going to be not a lot
15 of these things, maybe a dozen or so. The competition is
16 going to be pretty fierce. It's going to be hard to
17 appeal to this group and not to that group when the ads
18 are being put on the back of buses to participate. That
19 should the worst happen and there be no offering or
20 somebody withdrawing from a region, which I don't think
21 will occur, there always is the fallback plan. When
22 that's not the case there is the fact that the others will
23 try to be scarfing up that business.

24 So what we should do is try and direct CMS and

1 attention to providing the protections that will ensure
2 that all of this way does turn out this way, but not
3 pursue the nightmare of the analysts and assume that this
4 is going to take place.

5 MR. HACKBARTH: Let me sound my agreement with
6 that, and in particular I think it's important for the
7 people in the audience to understand that just the nature
8 of these things, we're exploring something new and
9 different and there's a tendency, a natural tendency I
10 think to try to identify potential problems. Certainly
11 there's a lot of complexity and a lot of opportunity for
12 things to go amiss. But keep it in context.

13 We're not rendering judgments, but trying to
14 learn, understand, anticipate, and help other people
15 anticipate. Certainly as Jack pointed out, a lot of work
16 is being done to make it go well, and we need to from time
17 to time acknowledge that and recognize that.

18 So thank you, Jack and Joan, for excellent work
19 on this and we need to move on to our next topic which is
20 defining long-term care hospitals.

21 DR. KAPLAN: Good morning. In this presentation
22 I'll briefly review the research findings presented at the
23 March meeting and also present two additional analyses
24 designed to answer questions you raised at the March

1 meeting. Then Carol will present some examples of
2 criteria we've developed that Medicare can use to better
3 define long-term care hospitals and appropriate patients
4 for them. At the end of the presentation we'll ask you to
5 discuss the draft recommendations and the draft chapter.

6 As we've told you before, growth in the number
7 of long-term care hospitals has been rapid at 12 percent
8 per year from 1993 to 2003. Recently growth has
9 accelerated. During fiscal year 2003 22 long-term care
10 hospitals opened. That same number opened in the first
11 six months of fiscal year 2004. From 1993 to 2001
12 Medicare spending quintupled from \$398 million to \$1.9
13 billion. The number of long-term care hospital cases
14 increased 24 percent from 2001 to 2002. As the number of
15 long-term care hospitals continue to grow they may find it
16 more difficult to fill their beds with appropriate
17 patients.

18 Long-term care hospitals have very high payment
19 rates. On the screen is a comparison of 2004 per-
20 discharge rates by setting for five diagnoses common in
21 long-term care hospitals. Like any prospective payment
22 system, financial incentives encourage these facilities to
23 admit patients with the least costly needs within a case-
24 mix group.

1 At the last meeting you questioned why long-term
2 care hospitals are located where they are. Using
3 multivariate analyses we found no relationship between the
4 presence of a long-term care hospital and the share of the
5 sickest patients. We found a negative relationship with
6 certificate of need. In previous research we found a
7 relationship of teaching hospitals to the presence of a
8 long-term care hospital, and the empirical analysis
9 confirmed that. The empirical analysis also confirmed the
10 strong presence of long-term care hospitals in the
11 southern parts of the nation.

12 Now I'm going to briefly review the findings I
13 presented last month. As you will recall, we had two
14 qualitative components to this research and a quantitative
15 component. For the quantitative work we used episodes of
16 care. In the full dataset we had 4.3 million episodes and
17 we created two subsamples to examine if the results differ
18 for patients who are more likely to be admitted to long-
19 term care hospitals.

20 To be as conservative as possible in our
21 research this year we did several things to control for
22 severity of illness. First we used every clinical
23 variable available from the administrative data. In
24 addition, we used statistical methods to control for

1 severity of illness, including an instrumental variable
2 approach to control for unmeasured severity.

3 As you remember, we found that the role long-
4 term care hospitals play is to provide post-acute care to
5 a small number of medically complex patients, less than 1
6 percent of patients discharged from acute hospitals.
7 These patients are more stable than ICU patients but
8 generally do not have all their underlying problems
9 resolved at admission to the long-term care hospital. A
10 diagnosis of tracheostomy with ventilator support is the
11 single strongest predictor of long-term care hospital use.
12 But patients with tracheostomies represent only 3 percent
13 of long-term care hospital cases. As severity level
14 increases, the probability of long-term care hospital
15 increases.

16 Supply of long-term care hospitals matters,
17 especially when they are hospitals within hospitals.

18 We found that acute hospitals and SNFs are the
19 principal alternates to long-term care hospitals. We
20 found that long-term care hospitals users have shorter
21 lengths of stay in the acute hospitals than non-LTCH
22 users. Shorter lengths of stay suggest that acute
23 hospitals and long-term care hospitals are substitutes.

24 We also found that freestanding SNFs are a

1 principal alternative to long-term care hospitals in areas
2 with and without long-term care hospitals.

3 On average, long-term care hospitals users are
4 more costly Medicare compared to clinically similar
5 patients who use alternative settings. For patients with
6 the highest probability of using a long-term care hospital
7 we found a positive but statistically insignificant
8 difference in Medicare spending for the episode.

9 Regardless of the method we used, we found that
10 long-term care hospital users had lower readmission rates
11 than simpler patients treated in alternative settings.
12 This is what we would have expected because long-term care
13 hospitals have to have the capacity to treat hospital-
14 level patients. Our results for death in 120 days are
15 inconclusive.

16 Last month you expressed concern about whether
17 to reduced probability of readmissions among long-term
18 care hospital users would affect our results on total
19 spending for episodes. We did two analyses to ask you
20 question.

21 First we examined total episode spending for the
22 80 percent of patients who aren't readmitted. Second, we
23 roughly estimated the effect of the lower probability of
24 readmissions on total spending among long-term care

1 hospital patients. With both analyses we found that when
2 long-term care hospital admissions are not targeted their
3 patients cost Medicare more. When long-term care hospital
4 care is targeted to the patients most likely to use long-
5 term care hospitals the difference in spending for those
6 patients and patients who use alternative settings are not
7 statistically significant. In other words, a much shorter
8 way to say it is, the story did not change.

9 The main conclusions from our study are that
10 when admissions to long-term care hospitals are not
11 targeted to the sickest patients, long-term care hospital
12 patients tend to cost Medicare more than patients treated
13 in alternative settings. Based on our analysis, we
14 conclude that long-term care hospital care needs to be
15 targeted to medically-complex patients that generally
16 cannot be treated in less costly settings.

17 Now Carol will talk about criteria to better
18 target long-term care hospital care.

19 MS. CARTER: We had several goals in mind in
20 developing examples of criteria for long-term care
21 hospitals. First and foremost, we wanted to clearly
22 distinguish this level of care from other settings, most
23 notably SNFs. We wanted the criteria to be feasible to
24 administer, both for CMS and for the hospitals. The

1 criteria should establish clear expectations and hold
2 providers accountable for their actions, and reinforce the
3 provision of high-quality care. We wanted the criteria to
4 be consistent with the payment policies of other PPSs. In
5 the longer-term, the criteria should facilitate the
6 adoption of a common patient assessment tool and
7 classification system across post-acute care settings.

8 During our site visits and numerous interviews
9 we were consistently told about the features of long-term
10 care hospitals that distinguished these facilities from
11 other settings, most notably SNFs and rehab facilities.
12 This is what they told us. They treat sicker patients and
13 that the majority of their patients are likely to improve.
14 They frequently use admission criteria to screen patients.
15

16 Many told us about the daily physician
17 involvement that their physicians have with their
18 patients. The level of care that they provided was fairly
19 intensive, ranging from six to 10 hours of licensed
20 nursing care hours per day. They had respiratory
21 therapists available 24 hours a day. They hired physical,
22 occupational, speech and respiratory therapists and had
23 them of staff. And they had multidisciplinary teams
24 preparing and carrying out treatment plans.

1 Based on these examples we developed example
2 criteria that could be used to ensure that long-term care
3 hospitals treat medically-complex patients. On the next
4 slide you see examples of facility-level criteria.

5 First, each hospital would establish a patient
6 review process that screens patients prior to admission
7 and periodically throughout their stay and assesses the
8 available options when patients no longer meet continued
9 stay criteria. The purpose is to have each facility have
10 a clear and uniform process that is used to assess each
11 patient.

12 A standard assessment tool would eventually be
13 used by all long-term care hospitals. This tool needs to
14 provide reliable and valid clinical assessments of
15 patients. Many facilities already use patient assessment
16 tools such as the Apache 3 system. We think all
17 facilities should use the same tool as a way to ensure
18 consistency across facilities in how patients are
19 assessed.

20 Strong physician presence and active involvement
21 with the planning and provision of patient care was a key
22 feature distinguishing long-term care hospitals from SNFs.
23 One criterion that could establish expectations regarding
24 the types of activities that physicians would be involved

1 in and their availability.

2 We think consulting specialists should be on
3 call and able to be at a patient's bedside within the
4 hour.

5 We think the current average length-of-stay
6 requirements should be retained in the near term as yet
7 one more way to ensure that patients require a high level
8 of resources. Over time as the patient criteria clearly
9 delineate the patients appropriately treated in this
10 setting we would reevaluated the need for this criterion.

11 Multidisciplinary teams would plan and carry out
12 treatment plans. Given the diversity of patients we
13 expect the staff to have a mix of specialized expertise
14 including wound care experts, respiratory therapists
15 capable of rescuing patients, PT, OT, and speech
16 therapists, and staffs capable of providing end-of-life
17 counseling.

18 Examples of patient criteria are on the
19 next slide. They would ensure patients admitted to long-
20 term care facilities require an intensive level of
21 resources, have good chance of improvement, and cannot
22 generally be treated in other less costly settings.
23 National admission and discharge criteria would be
24 developed for each major category of patients, such as

1 medically complex and respiratory patients. The criteria
2 would specify clinical characteristics such as blood
3 pressure, respiratory insufficiency, or open wounds,
4 depending on the type of patient. And the criteria would
5 delineate the need for specific types of treatment such as
6 IV medications, pulmonary monitoring, ventilator support,
7 and GE suctioning, again depending on the type of patient.
8 Patients who do not meet the admission criteria would be
9 expected to be admitted to a different level of care.

10 Discharge criteria could be specific to the
11 discharge destination. For example, discharge criteria
12 for a patient headed to a SNF could be different from
13 those headed home.

14 To distinguish the types of patients treated in
15 this setting from patients treated in other settings a
16 high share of patients, for example, 85 percent, would be
17 classified into broad categories such as complex medical,
18 complex respiratory, cardiovascular, ventilator weaning,
19 and extensive wound care.

20 To ensure that long-term care hospitals treat
21 the most severely ill one criterion could be that a high
22 percentage of patients need to be assessed at admission at
23 high severity levels. For example, 85 percent of patients
24 would be assessed at the APR-DRG levels three or four.

1 Patients who are less sick can be treated in less costly
2 settings. We appreciate that when the criteria are first
3 implemented it will take time for the industry to adjust
4 to them. Therefore at first this criterion could start at
5 a lower share. Over time we would expect the share
6 required to increase to compensate for changes in coding
7 that are likely to occur.

8 Admitting patients who require a certain amount
9 of skilled care is another way up to ensure that patients
10 are appropriate to this level of care. For example, a
11 criterion could state that patients required 6.5 hours per
12 day of licensed nurse, respiratory therapist or physical
13 therapist time.

14 Now Sally would like to walk you through a draft
15 recommendation.

16 DR. KAPLAN: On this slide you see the first
17 part of the first draft recommendation. There are
18 actually two slides for this.

19 It reads, the Congress and the Secretary should
20 collaborate to define long-term care hospitals by facility
21 and patient criteria that ensure that patients admitted to
22 these facilities are medically complex, have a good chance
23 of improvement, and generally cannot be treated in other
24 settings. It goes on, facility-level criteria should

1 characterize this level of care by features such as
2 staffing, patient evaluation and review processes, and mix
3 of patients. Patient-level criteria should identify
4 specific clinical characteristics and treatment
5 modalities.

6 We estimate that the beneficiary and provider
7 implications are that the adoption of criteria would
8 expand access for patients who actually need long-term
9 care hospital level care. Medicare spending implications
10 are that stringent criteria will result in reduced
11 spending.

12 The second recommendation is that the Secretary
13 should require the quality improvement organizations to
14 review long-term care hospital admissions for medical
15 necessity and monitor that these facilities are in
16 compliance with defining criteria.

17 The beneficiary and provider implications are
18 that enforcement of the criteria would expand access to
19 patients appropriate for LTCH level care. Medicare
20 spending would increase for QIOs.

21 Before you begin discussing the recommendations
22 we want to note that ensuring the appropriate use of long-
23 term care hospitals requires a two-pronged approach.
24 First, criteria such as the ones we've outlined well help

1 ensure that long-term care hospitals already in operation
2 treat patients who require this level of care. But we
3 recognize that in the longer-term refinements to the pre-
4 existing PPSs for acute hospitals and SNFs are needed to
5 make sure that the development of long-term care hospitals
6 is not simply the byproduct of shortcomings in these other
7 payment systems.

8 On the inpatient PPS side there are three
9 policies that we think warrant further study. First, a
10 classification system that reflects the severity of
11 patients may improve the matching of payments to patient
12 costs and could make acute hospitals financially neutral
13 to treating the complex cases that are currently
14 transferred to long-term care hospitals. This would also
15 likely lower the number of outlier cases that routinely
16 get transferred to long-term care hospitals.

17 Second, the current outlier policy we believe
18 needs to be studied. The threshold and cost-sharing
19 requirements may contribute to acute hospitals unbundling
20 care to long-term care hospitals, and modifying these
21 policies could make acute hospitals less prone to transfer
22 cases who they could treat themselves.

23 Third, clear rules regarding hospitals within
24 hospitals will ensure that hospitals do not discharge

1 patients prematurely for financial gain. CMS has
2 expressed their concern about hospitals within hospitals a
3 number of times and we look forward to seeing what they
4 do.

5 On the SNF PPS side, we and others have noted
6 the shortcomings in the current RUGs classification
7 system. Refinements that better target patients to
8 medically-complex patients and away from being driven by
9 the provision of therapy services may encourage more SNFs
10 to admit certain types of patients that could be
11 appropriately treated in this lower cost setting.

12 That ends our presentation.

13 DR. MILLER: On the implications from provider,
14 beneficiary and on the spending, really I think what we're
15 saying at this point is, we don't know. We're talking
16 about draft criteria. We don't know what would be
17 adopted. There could be some increased access for some
18 sets of patients. There could be some effect on the
19 current spending curve but I don't think we really know.
20 When we get to putting this in the chapter I think this is
21 going to be hard to draft and it's probably going to say
22 in fancy words, we're not real sure. I think that's what
23 we're trying to get across here.

24 MR. DeBUSK: I think this is an excellent

1 chapter. There's a lot of time, lot of work gone into
2 this. That's quite evident. I want to back up to page
3 13, examples of facility-level criteria. The standard
4 patient assessment tools, could you expand on that a
5 little bit? What's out there at present?

6 MS. CARTER: There are a number of different
7 patient assessment tools. The one that we looked at and
8 talked the vendor about was the Apache system. We're not
9 recommending it but it is one out there, but there are
10 many others. Many of the hospitals and sites that Sally
11 visited were using admission criteria screening.
12 InterQual is another one.

13 MS. DePARLE: I agree that we've really done a
14 lot of work in the last 18 months on this and it's
15 excellent. I just want to raise one thing. In the
16 discussion of the conclusions we said when admissions to
17 LTCHs are not targeted their patients tend to cost
18 Medicare more than patients in alternative settings. We
19 discussed last time the readmissions and you did obviously
20 a lot more work to discover that it still cost more.
21 Remind me what we know? We cannot, I take it, draw any
22 conclusions but the quality or the outcomes being better
23 or worse?

24 DR. KAPLAN: No, we can't. The only outcome

1 measure that we have is the readmissions. There is no
2 patient assessment instrument in these facilities and
3 that's one thing they would hope to -- we did have a
4 discussion of quality in the chapter, that that's one of
5 the things we would hope to see that would come out of
6 these criteria.

7 MS. DePARLE: Is that implicit in our
8 recommendation about criteria, that there be a patient
9 assessment? Because it seems to me, down the road we're
10 going to want to be able to look at these various
11 settings. If we got better results I'd be willing to pay
12 more I think.

13 DR. KAPLAN: The recommendations basically say
14 we need criteria and generally describe what we expect the
15 criteria to accomplish, and then in the chapter we discuss
16 the examples of criteria we think would be useful in
17 greater detail. The patient assessment instrument and the
18 quality measurement are discussed there.

19 MS. DePARLE: I guess that leads me to the other
20 question I had. We talked about this a little bit the
21 last time. I'm still not clear on what CMS could do on
22 its own now, understanding that CMS has a lot of other
23 things to do. But if they wanted to do, for example, a
24 patient assessment instrument and asked the LTCHs to use

1 that, as well as other settings, as you point out in the
2 chapter do use patient assessment instruments, could they
3 do that? We use this language about collaborating with
4 Congress. Is that because we're not clear how far CMS can
5 go on its own?

6 DR. MILLER: I think there's a couple answers.
7 We think that there are lots of things that we're talking
8 about within this criteria that probably can be done
9 administratively. Then what really falls between the
10 Secretary and the Congress I think we are a little bit
11 unclear on. So for the purposes of this discussion we've
12 cast it as both actors being involved in this. There's
13 some murkiness there.

14 MS. RAPHAEL: I think it's important somehow to
15 put a little broader frame around this chapter which I
16 think has really come a very, very long way. I think what
17 we're saying based on this chapter is that the long-term
18 care hospitals are part of the post-acute care spectrum.
19 They have a role to play for a certain set of patients,
20 and based on a certain set of criteria that we would like
21 to see come into play. So I think it's important to set
22 that there because I think where we're headed is trying to
23 have a more rational post-acute care system, hopefully
24 where patients who will likely have better outcomes in

1 certain settings somehow are more likely to go there.

2 The other things I was going to ask you, I think
3 Mark answered a question I had which was the impact. If
4 all of this were to come to pass what would it all amount
5 to. I understand that it's hard to capture that. But
6 several other questions that I had based on the letter
7 that we received, one was about the role of rehab in these
8 settings, because rehab expenditures seem to be
9 particularly costly when compared to SNF for these
10 settings. I was wondering if you could comment on the
11 role of rehab. When is it appropriate for rehab patients
12 to go to LTCHs versus rehab facilities? I wasn't entirely
13 clear.

14 Secondly, could you clarify the issue around
15 staffing? Because a point that's made in the letter is
16 that in SNFs the nursing staffing component encompassed
17 actually unlicensed aide time. I guess I'd like to have
18 that cleared up in terms of what we mean.

19 Lastly, maybe it's not for today's session but I
20 would like to learn a little more about the QIOs. They
21 don't do any of this now. How well equipped are they to
22 take on this role in the future?

23 DR. KAPLAN: I'm going to go in reverse order to
24 your questions. QIOs currently have in their scope of

1 work that they review 116 randomly selected cases from
2 long-term care hospitals of month. That just began in
3 January. So they are becoming extremely familiar with
4 long-term care hospitals and the cases. Some of them
5 already use some of the criteria that we looked at in
6 considering what type admission criteria and discharge
7 criteria you might want to use or might need, and some of
8 the QIOs are already using that criteria for long-term
9 care hospitals.

10 So I think that they may not be all that
11 familiar with them now but they are becoming much more
12 familiar.

13 DR. NELSON: Sally, do they make site visits or
14 do they just do a record check?

15 DR. KAPLAN: That I don't know.

16 DR. MILLER: I think our impression is that what
17 they're doing is claims analysis and medical records
18 review like they've done in other kinds of settings. I
19 don't think they're going to the facilities and doing
20 conditions of participation type inspections if that's
21 what you're referring to. I'm pretty sure they don't do
22 that kind of stuff.

23 DR. KAPLAN: I think this is retrospective.
24 It's not they see the patient when the patient is in the

1 facility.

2 DR. NELSON: That's what I wondered, if it was
3 concurrent or retrospective. Thank you.

4 DR. KAPLAN: Staffing, aides and SNFs. One of
5 the big points that the long-term care hospitals that we
6 visited on our site visits made was what distinguished
7 them from SNFs were many things, but one of the biggest
8 points was, first of all, daily active intervention of
9 physicians, and staffing. That they provided professional
10 staffing. They did not have a lot of aide care in the
11 long-term care hospital. That is what we are trying to
12 accomplish, to make sure that these are not SNFs and that
13 they aren't souped-up SNFs. So that is why we have put
14 the staffing.

15 The 6.5 hours actually comes from InterQual
16 criteria. My understanding is this is the level that step
17 downs from ICU units have that level of staffing, which is
18 also what we were told the long-term care hospitals told
19 us, that they're step downs from ICU units.

20 DR. MILLER: The other part of her question had
21 to do with aides, which we did talk to several people
22 about in the industry. Our criteria says very carefully,
23 licensed. The issue that they brought to us is, can we
24 reach this criteria by using somebody other than nurses?

1 Can we respiratory therapists, wound specialists, that
2 kind of thing. In contemplating this work we see that
3 that wouldn't be an issue. We do not see them reaching
4 this level through aides, however. I thought that was
5 part of your question.

6 DR. KAPLAN: Now let me go to your last question
7 which was the rehab and the long-term care hospitals. I
8 think one of our concerns is that there are -- the
9 payments in long-term care hospitals for the very same
10 patients that are in rehab are very attractive. I used
11 the major joint replacement as a good example, \$67,000 a
12 case in the long-term care hospital versus \$17,000. That
13 is for a person with the most ADL impairment and the most
14 comorbidities in the rehab facilities. So that's the most
15 you could get for a major joint replacement in a rehab
16 facility.

17 Our concern is that long-term care hospitals do
18 not become very highly paid rehab hospitals. So this is
19 not to say that patients in long-term care hospitals
20 wouldn't receive rehab. This is not to say that a patient
21 who may have been a major joint replacement but had lots
22 of comorbidities and really couldn't be taken care of in a
23 rehab hospital couldn't go to a long-term care hospital.
24 This is really to try and build a line between rehab

1 hospitals and long-term care hospitals.

2 DR. MILLER: And the line is focused on the
3 severity of the patient.

4 DR. KAPLAN: Yes, on the severity of the
5 patient.

6 DR. ROWE: I have two points. This is very
7 nice work; congratulations.

8 One is, you mentioned on page 14 and one of your
9 recommendations that the average length of stay should be
10 greater than 25 days, and I had two thoughts about that.
11 One is I wonder whether that's average live discharges.
12 These are very, very complex patients. A patient gets
13 admitted, dies after three days, is that counted as a
14 three-day length of stay as we're calculating it?

15 The second is, would we be better off using the
16 median than the mean? Because there are some patients in
17 these facilities who are there for like two years and then
18 you can have a whole bunch of patients there for five days
19 and you have an average length of stay greater than 25,
20 and that's not really the spirit here.

21 So I would just ask you to think a little bit
22 about whether that is really the right -- if we're going
23 to have some new recommendations -- I don't know what the
24 distributions are. I haven't seen them. I'm just

1 thinking about that that maybe we could improve that if we
2 looked at some data.

3 The second point I think is more important and
4 it goes to Carol's comment about the rehab and the
5 business you just said, Sally, about trying to divide
6 rehab hospitals from long-term care hospitals. The first
7 rule is *primum non nocere* here; above all, do no harm. I
8 think it's great to divide these institutions as long as
9 we're not cutting any babies in half here. I think some
10 of these institutions have evolved along a pathway where
11 they're basically 50 percent rehab hospitals where they're
12 probably getting overpaid for those patients, but they
13 have to keep them in 25 days which is really not what they
14 want do if they're really a rehab hospital, and 50 percent
15 long-term care hospitals. They don't want to be a
16 hospital in a hospital because then they'd have to have
17 different CFOs and medical directors and governances, et
18 cetera.

19 So going forward I think these are a terrific
20 set of recommendations. Looking backward I would hope
21 that our work reflects the possibility that there are some
22 institutions, and we could have very strict criteria, that
23 perhaps by virtue of the way they have evolved and the
24 role they play we might consider approaching differently.

1 I'll leave it at that.

2 DR. REISCHAUER: Of course your first
3 recommendation might be cutting some of these babies in
4 half.

5 DR. ROWE: I understand. I'd like to see what
6 the data look like, and if you did both things then maybe
7 would be okay. I understand. If you just did the first
8 thing it might make it worse, not better.

9 MR. HACKBARTH: We're trying to put together
10 here a conceptual framework defining how this fairly
11 expensive resource is used, and as we do that there may be
12 some unique circumstances that arise out of historical
13 factors that make this less than the perfect fit for
14 particular institutions. I think we ought to acknowledge
15 that explicitly in the text. Having said that, I
16 don't think this is the appropriate forum to try to deal
17 with those circumstances but we ought to acknowledge that
18 they may exist.

19 DR. NEWHOUSE: In that paragraph I'd like to
20 suggest that we say something about we don't envision that
21 there would be any entry under these criteria. That is to
22 say, or I envision saying something like, the original
23 criterion for defining a long-term hospital was solely
24 that you had an average length-of-stay of more than 25

1 days. That encompassed a variety of institutions notable
2 for their heterogeneity and that, as Jack said, some
3 circumstances may dictate that we would treat some of
4 these people that qualified initially differently but that
5 we explicitly say something about entry. Because if
6 there's anything we've seen about the long-term hospital
7 industry it's entry. We don't want to set up exceptions
8 that encourage entry into those exceptions.

9 MR. HACKBARTH: I think that's an excellent
10 addition. Thanks.

11 MR. SMITH: Thank you very much. This has been
12 good work over the last year. Most of what I wanted to
13 say has been said so I won't repeat it. Looking at
14 recommendation A, we say that these folks generally can't
15 be treated in other settings. A big part of the argument
16 of the chapter is that they are routinely treated in other
17 settings. I think we need to be careful here. Figuring
18 out what the patient criteria are seems to me to be the
19 critical part of both the argument in the chapter and of
20 the recommendations.

21 We have a suspicion that there are some people
22 who would be better off treated with the more complex
23 apparatus available in the long-term care hospital but
24 really don't say that. Instead we hint at it. On the

1 other hand, our current practice is that they are
2 routinely treated in acute-care hospitals and SNFs and in
3 some cases, rehab facilities. If we really believe the
4 line we used at the end of the first paragraph of
5 recommendation A, that's what we ought to turn our
6 attention and we ought to underscore that in the text of
7 the chapter.

8 MR. MULLER: My thanks as well for really
9 elaborating our understanding of this. If I can take us
10 back to the slide on page three and the question of the
11 classification of patients. As Carol said, if we have the
12 appropriate care in these hospitals vis-a-vis alternative
13 settings then this is a good place for them in the
14 continuum of care.

15 But in looking at that table, I must say if
16 indeed the acute hospital is a low cost provider we should
17 gold plate this slide as the first time we've ever shown
18 that. But what are we showing here in terms of the mix of
19 patients, because that would truly be a pleasant surprise
20 to some of us who always defend the alternative? So what
21 are we seeing here in terms of classification of patients?
22 Because they truly are comparable patients and we know
23 from what you said earlier, the LTCHs are not in all parts
24 of the country and you've shown the predominance of them

1 in four states or so. What are we really measuring here
2 across these patient populations in terms of
3 comparability?

4 DR. KAPLAN: For instance, the stroke is DRG-14,
5 as an example. That is the per-case payment, a
6 standardized amount that an acute hospital received for
7 each stroke patient. That is the standardized amount that
8 a long-term care hospital receives for each person that
9 has a stroke, that has DRG-14. It's a little bit more
10 complex.

11 MR. MULLER: So there's obviously differences in
12 acuity --

13 DR. KAPLAN: Yes.

14 MR. MULLER: -- because otherwise you would say,
15 everybody should just stay in an acute-care hospital then
16 and not go to these --

17 DR. KAPLAN: If we could get them to stay in
18 acute-care hospitals that might be our choice, but that
19 hasn't been what we've got -- we haven't been able to make
20 that happen. That's one of our solutions was that we need
21 to look at the acute-care hospital payment system to see
22 if there are ways that we could provide incentives for
23 acute-care hospitals to keep more of these patients.

24 DR. REISCHAUER: I was wondering whether if you

1 adjusted the acute-care hospital stroke for similar
2 severity level and then look at outlier payments
3 associated with that as well what would the number be?
4 You don't mislead us in any way in your description of
5 this, but that could be the logical comparison really.

6 DR. KAPLAN: I don't think I can do that for the
7 June report. If you would like that next year maybe, but
8 not this year.

9 MR. HACKBARTH: Even accepting that you can't do
10 that specific calculation, it might be good to add some
11 additional text that explains that this is not necessarily
12 and apples to apples comparison of similar patients.

13 DR. ROWE: Why don't you take the acute hospital
14 data out? That's not really what we need anyway. Really
15 it's the long-term care versus the inpatient rehab versus
16 the SNF.

17 MR. MULLER: In many parts of the country where
18 there aren't the long-term care that in fact is -- so
19 probably in terms of the incidence of cases it's where --
20 that's where the care is. So I think Bob's point about
21 what's the real underlying payment when you look at the
22 whole payment. But still, outliers aren't that good they
23 can go from six to 31 or from eight to 44.

24 MR. SMITH: But the first, third and fourth

1 columns up there are subsequent to the second column. In
2 that sense this really isn't apples to apples. It's
3 \$6,000 plus \$31,000. It's \$6,000 plus \$34,000. So we
4 should really take that column out of here.

5 DR. KAPLAN: I think that's a good suggestion,
6 We can also put in the text too that we aren't measuring
7 by severity level on this.

8 MR. MULLER: I don't agree with David's
9 conclusion because if they don't go to a long-term care
10 hospital or a rehab hospital then that's it.

11 MR. SMITH: Right, but the comparison is when
12 they go.

13 MR. MULLER: No, the comparison is, what does it
14 take to take care of a patient? And if the patient can
15 only be in an acute hospital because there's no
16 alternative, that's what it takes. So the patient is the
17 comparative point, not -- then you look at the patient
18 across different settings.

19 MR. SMITH: That's right. But then it would be
20 additive in many and in some cases, most cases, right?
21 The episode of care is not always longer than the acute
22 stay, but often is.

23 MR. MULLER: Yes, but then oftentimes it's in
24 hospice or some other kind of nursing home. Not in a

1 rehab. Probably then the nursing home is more likely.
2 Probably in terms of the incidence of care around the
3 country I would guess the most common is the acute
4 hospital followed by the nursing home in terms of where
5 the bulk of the cases are. Then in settings where there
6 are rehab hospitals and long-term care you have this
7 payment pattern that's described here. But if you just
8 look at flat out incidents, my guess is, the way you said
9 it, it's column two and four, not a combination of -- just
10 in certain cases about the country.

11 MS. BURKE: At the risk of being positioned as
12 being opposed to long-term care hospitals I will make the
13 following comment. Let me first ask a question. In the
14 context of the growth of long-term care hospitals note is
15 made in the chapter about the particular increase in the
16 in-house or the hospital related long-term care hospital
17 activities. I wondered what we knew about the proximity
18 of that growth, those particular institutions, to other
19 freestanding? And to what extent we can infer that
20 there's a certain amount of defensive action that has
21 taken place; i.e., are we seeing the growth in the in-
22 house hospital-based long-term care units in close
23 proximity to freestanding long-term care?

24 Is this a market-driven kind of issue? Are they

1 essentially trying to compete for patients? Are you
2 seeing, for example, inpatient facilities developing in
3 areas where there are no long-term care freestandings, or
4 do they tend to be in the same markets? That would be my
5 first question. What do we know about that? So to what
6 extent is this a defensive mechanism?

7 Secondly, I have a question as to whether there
8 is any inherent difference between those two types of
9 facilities. You note that on average those that are
10 located within hospitals tend to be smaller, that their
11 referral patterns tend to be slightly different, neither
12 of which is terribly surprising. Are there any other
13 aspects of those facilities, either the patients they see,
14 the costs that are reported, the nature of the services,
15 the lengths of stay, the mix of specialists or staffing
16 patterns that are different between those two kinds of
17 facilities? I would be interested in that as well.

18 Going back to David's point, and he said it far
19 better than I did, and I think also touching on Carol's.
20 I am fundamentally concerned about a statement which
21 suggests that these are patients that because of the
22 nature of the acuity of their condition requires what is
23 now provided in these facilities when in fact the majority
24 of these patients are being seen in other kinds of

1 facilities around the country. So I think you're very
2 wise to have suggested that part of what must happen is to
3 re-look at the payment system for other facilities that
4 are in fact taking care of the majority of the patients
5 that present themselves in exactly these situation,
6 because it presumes that people that don't have these in
7 their neighborhoods are somehow disadvantaged. So I
8 think your point to make that part of our recommendation
9 ought to be highlighted, that the bulk of these patients
10 really are being cared for arguably in other settings.
11 And let us not assume that the only answer is to develop
12 one of these in your neighborhood. But rather let's find
13 something to do about the payment system that effectively
14 deals with the patient irrespective of where the patient
15 is located. Unless there's something fundamental that we
16 ultimately want to say about other facilities never
17 fundamentally being able to take care of these patients,
18 that a hospital will never be able to take care of a step-
19 down sub-acute patient, which I find somewhat hard to
20 believe. That somehow someone who's been discharged from
21 a unit can't be taken care of in a hospital. It concerns
22 me about hospitals.

23 So I think that point ought to be, perhaps,
24 emphasized even more strongly, that we really need to look

1 at where patients are being treated, make sure that the
2 payment system reflects the needs of the particular
3 patient. But I would also in future work like to
4 understand the nature of this sort of what has occurred in
5 the growth of these particular facilities in hospitals and
6 what is that suggesting to us about those particular
7 hospitals and the way they're structured and what they're
8 responding to?

9 MR. HACKBARTH: Could I address the last point?
10 I think the point that Dave made about the language in
11 draft recommendation, that generally cannot be treated in
12 other settings, is exactly right, and I think it is at
13 odds with an important made in the chapter.

14 Moreover, I strongly agree, Sheila, that the
15 recommendations related to the acute hospital, severity
16 and outliers and also looking at the SNF payment system, I
17 think they are critical parts of this chapter. So when we
18 get to the draft recommendation what I was going to
19 propose is to delete that last phrase about generally
20 cannot be treated in other settings.

21 DR. KAPLAN: Let me just briefly try and answer
22 your question about hospitals-within-hospitals. A lot of
23 what you're asking I can't answer. I can't tell you but
24 difference in staffing or difference in cost structure

1 because we don't have PPS costs. I think to look at it in
2 the pre-PPS world is fishy at this point.

3 We did make an attempt to see if we could find
4 differences using our multivariate models and the
5 instrumental variable approach, to find the differences
6 between the hospital-within-hospital patients or episodes
7 and the freestanding episodes, and we really were not able
8 to get stable parameters. So we have to conclude at this
9 time that there isn't a difference. I want to make that
10 real tentative because it's really because we couldn't get
11 the stable parameters.

12 Now if we do re-do this work post-PPS we might
13 find a difference.

14 MS. BURKE: Should I assume, because it doesn't
15 suggest otherwise, that the growth in these particular,
16 the hospital-based, are following the same geographic
17 pattern, or are they more distributed?

18 DR. KAPLAN: I think they're more distributed.
19 First of all, almost all of the latest growth is hospital-
20 within-hospital. They now represent 50 percent of the
21 long-term care hospitals. CMS makes the point that every
22 long-term care hospital that has opened up since the PPS
23 went into effect is a hospital-within-hospital.

24 There is some that have opened up in markets

1 where long-term care hospitals already existed. For
2 instance, the 35, 36 long-term care hospitals that are
3 down in Louisiana, there are a couple freestanding ones
4 down there. But most of those are hospitals-within-
5 hospitals. I would say that the new trend is almost all
6 to hospital-within-hospital. So anything that's opening
7 up since 2001 --

8 MS. BURKE: But is it largely staying in the
9 same general geographic area?

10 DR. KAPLAN: No, they're spreading out more.

11 MS. BURKE: So they're going north, they're
12 going west, they're going central.

13 DR. KAPLAN: Right. I'll give you an example.
14 For instance, in St. Louis there was a long-term care
15 hospital, a Kindred long-term care hospital, the old
16 Vencor chain that's been here since, I want to say the
17 early '90s. Now in the last few months there's been a
18 hospital-within-hospital that's opening, one or more in
19 St. Louis. So it's kind of hard to tell what I think
20 you're trying to get, is it market or is it because
21 competition that the hospitals are opening them up?

22 MS. BURKE: Right, or whether -- part of this is
23 my trying to understand how much of this is really driven
24 by the need for these services and by patient needs that

1 aren't being met by other capacity, and whether or not we
2 are seeing in fact the spread across the country or
3 whether they are staying largely in certain areas where
4 there's been a history and where the market might suggest
5 that there's an opportunity to compete for patients where
6 there's already been a pre-established presumption that
7 these are a better alternative. I'm just trying to
8 understand how widespread this has become as we look at
9 this going forward.

10 DR. REISCHAUER: Can I just add a footnote on to
11 that? Early in the chapter you mentioned that 80 percent
12 of the revenue of long-term care hospitals comes from
13 Medicare. We know there are some older ones and some
14 different types of ones. If we just looked at the new
15 ones and the hospitals-within-hospitals is this like 95
16 percent Medicare, so one would presumptively come to the
17 conclusion that it is an artifact of the Medicare payment
18 system that has created the growth that we're seeing?

19 DR. KAPLAN: I can only answer based on our site
20 visits, because we don't have cost report -- the share of
21 how much Medicare pays comes from the cost reports. We
22 don't have cost report since the PPS. Some of the
23 anecdotes we heard when we were out at site visits was
24 that more than 80 percent is coming from Medicare in some

1 of these facilities.

2 DR. WAKEFIELD: Just a couple of questions. On
3 the data that you have that show the long-term care
4 hospitals users have fewer admissions, will you remind me
5 what the categories of comparison were there? Lower than
6 just SNF or lower than readmitted back into the hospital,
7 rehab facilities, et cetera. So which category was that
8 comparison to?

9 Also related to that, would it be inappropriate
10 to suggest that after these criteria were put in place and
11 we started to say, because we're basically incenting that
12 patients be taken care of in different settings -- would
13 it be inappropriate to suggest that there be some tracking
14 of any changes in readmission rates after the
15 accommodation of these criteria? Would there be some
16 reason why we wouldn't want to do that, to make that kind
17 of a suggestion? I'm not suggesting it as part of a
18 recommendation but would that be a piece of information to
19 be looking at after the implementation, because we're
20 suggesting that there's some subset of patients that are
21 best treated in non-long-term care facilities, or treated
22 at least equally well. Would that be worth continuing to
23 take a look at?

24 Then unrelated to those two points, the

1 criterion that speaks staffing and the use of just
2 licensed personnel, that application of that criterion, it
3 sounds like you were suggesting that basically all long-
4 term care hospitals already staff maybe with just licensed
5 personnel or at least we're suggesting that they all
6 should, rather than using aides. Am I misunderstanding
7 that?

8 DR. KAPLAN: We're not suggesting that they not
9 staff with aides. What we're saying is for the staffing
10 level that we're talking about that aides would not count
11 towards that. Only licensed people would count towards
12 that.

13 DR. WAKEFIELD: Part of the reason why I was
14 asking that was because acute-care hospital staff by and
15 large, or many of them that I'm familiar with, staff with
16 nurse aides as part of that mix of staffing. But I take
17 your point, it's the counting of that level of staffing.

18 Then will you come back to my first point
19 for me?

20 DR. KAPLAN: Yes, I was going to answer your
21 first question. You were asking me whether the
22 readmission analysis, who the comparison was. If you
23 think of it, what we're comparing is people of equal
24 severity level. And we're comparing those that use long-

1 term care hospitals versus those that don't. So we
2 aren't comparing against any particular setting. We are
3 comparing those who used other settings.

4 DR. MILLER: Who use post-acute care.

5 DR. KAPLAN: Yes, it would be. It's an apple to
6 apple comparison.

7 DR. WAKEFIELD: So based on the work you've done
8 would you find value in continuing to take a look at those
9 readmission rates between those that use long-term care
10 hospitals and all others over time after these criteria
11 were applied and the patients start to shift out
12 differently in terms of where they're actually getting
13 services? Would that help tell us something about what
14 might have been triggered or not by the application of
15 these criteria?

16 DR. KAPLAN: I don't think it would hurt to
17 track it. I guess the point that I come to on the
18 readmissions is it's one of the few things that we have --
19 I actually think it's a fairly weak outcome measure -- for
20 facilities that have to be licensed as a hospital. They
21 should be able to handle almost everything, so we would
22 expect those readmissions. But I think readmissions are
23 always an important issue to track in every setting,
24 because Karen and the other quality people presented

1 readmissions for avoidable conditions are a huge quality
2 indicator.

3 So yes, I think we should. But at the same time
4 I don't think we want to bank on that one. I think we
5 need a lot more than that.

6 MR. HACKBARTH: Two more comments then we need
7 to turn to the vote.

8 DR. NEWHOUSE: I'd like to follow on where
9 Sheila and Bob were and go maybe a few steps further and
10 actually propose another recommendation, which is that we
11 suggest a moratorium on new hospitals-within-hospitals. I
12 see the hospital-within-hospital fundamentally is a threat
13 to the integrity of the prospective payment system, if you
14 can shift your long-stay patients off to another floor of
15 the hospital and get separately reimbursed.

16 As a second order and speculative point at this
17 point, but it may well be that those patients are actually
18 different than the patients in the freestanding long-term
19 hospitals, and we get into a kind of freestanding -- like
20 we have freestanding versus hospital-based SNFs and these
21 are really two different groups of patients and this
22 system doesn't fit the other one any way, although I'd lay
23 emphasis on the first point, that if we have a per-case
24 system for the acute hospital it seems to fundamentally

1 threaten that to set up a hospital-within-a-hospital where
2 you can shift your long-stay patients.

3 MR. SMITH: Very quickly. Ralph is surely right
4 that my suggestion of eliminating column two on page three
5 of that chart doesn't solve the apples to giraffes
6 problem, but leaving it there doesn't either. I wondered
7 whether or not we can get some episode data where it's
8 acute-care facility plus post-acute, or in those cases
9 where it is simply a stay in an acute hospital? So that
10 we really are looking at the episode here rather than the
11 current misleading use of the acute-care number in cases
12 where there's a discharge to a post-acute setting.

13 Second, Glenn, I think you're right about
14 changing recommendation A, but I think part of what you
15 said in doing that suggests yet another new recommendation
16 . Building on Sheila's observation, we're not going to
17 fix this simply on the long-term care hospitals side.
18 We've got to address both the SNF and acute-care PPS in
19 order to get them working together. I think that's where
20 Joe was headed, get them working together rather than
21 being payment-driven substitutes for each other.

22 Some maybe we can translate the observation that
23 Sally and Carol make at the end of the recommendations
24 into a third recommendation which urges the reforms that

1 they outlined in both the acute and SNF PPS as part of
2 getting this one right.

3 DR. KAPLAN: The only thing I want to say is
4 we've made the recommendation on SNFs three years in a row
5 now. I just want to point that out, that it has been
6 three years.

7 MR. SMITH: Just take advantage of the
8 opportunity to underscore our previous recommendation.

9 DR. KAPLAN: But I think we need more study of
10 the acute-care hospital before we can really -- I
11 personally feel strongly that we do need -- we might fix
12 things for long-term care hospitals, but we might be
13 messing things up for other sectors. I think it's a
14 bigger issue than just for the 100,000 discharges in long-
15 term care hospitals. That's my concern, is that we -- I
16 think it is important and I think it's work that we should
17 do, but I just don't know that we should make a
18 recommendation that CMS run off and fix something that we
19 haven't studied, especially if you consider the competing
20 demands on their time now with MMA. I think we want to
21 give them a little better direction than -- fix it how?

22 MR. HACKBARTH: Help me out. The something in
23 that sentence, fix something, was what?

24 DR. KAPLAN: Fix the acute hospital PPS. We've

1 already told them we want them to fix the SNF PPS.

2 MR. HACKBARTH: What I thought we were saying is
3 that -- we can reiterate the specific recommendation on
4 SNFs, and what I thought we were saying with regard to the
5 acute hospital is that we think these are areas that
6 require further study, as opposed to I don't think we've
7 got the foundation for saying we're recommending a
8 severity adjustment for inpatient PPS. We may well do
9 that in the future, but we don't have the foundation for
10 that established right now.

11 DR. KAPLAN: I'm sorry, I misunderstood what
12 David was saying. So you want to reiterate the SNF PPS -

13 MR. SMITH: We ought to do the SNF
14 recommendation and we ought to underscore the need to lay
15 the groundwork to --

16 MR. HACKBARTH: Exactly.

17 DR. ROWE: I don't want to prolong this. We've
18 gone a long time and I know you want to end this, but Joe
19 just suggested an additional recommendation about a
20 moratorium. I think if we we're going to do that we're
21 going to have to suggest until when? Usually moratoria
22 have -- until what happens? When is the end of a
23 moratorium? What are we trying to do, just call time-out?
24 Is it some kind of study or is it some kind of

1 clarification, or are we calling for a cessation?

2 MR. HACKBARTH: Here's my view of it. Over the
3 course of the last two meetings at least Joe and Bob and
4 Sheila and maybe some others as well have expressed
5 concern about the hospital-within-hospital phenomenon.
6 Personally I find the way they presented it pretty
7 compelling. I'm convinced that it's something to watch
8 and look at.

9 Personally though, I feel it's a bit premature
10 to go to the step of recommending a moratorium. I would
11 like to see more evidence, more data of the sort that
12 Sheila was asking for, comparing the hospital-within-
13 hospital to the freestanding, so that we have a
14 foundation, an analytic foundation for saying this looks
15 more, pardon the expression, like a PPS-unbundling tool
16 than an institution that is like the freestanding. I
17 don't think we have that factual foundation established
18 yet.

19 Now I know the counter-argument would be, don't
20 let them proliferate rapidly while you're getting the
21 data.

22 DR. REISCHAUER: You're increasing the sample
23 size.

24 [Laughter.]

1 MR. HACKBARTH: Personally I would prefer to do
2 the analysis first. A moratorium in the context of the
3 Medicare program is a pretty significant step and I don't
4 like to take steps without more analysis. My take on it.
5 Welcome any reactions to that.

6 MS. BURKE: I wouldn't disagree with you, nor
7 would I necessarily disagree with Joe. I think it is a
8 question of timing and making sure that we are fully
9 informed. I agree with you that we ought not today
10 contained make that decision without being fully informed.
11 I think there are a series of questions around the nature
12 of the patient they are serving, what it says more
13 fundamentally about the hospital and about the structure
14 of the payment system. It raises issues about transfers.
15 There are a whole series -- all these issues are wrapped
16 up with one another.

17 I think I would support your suggestion that we
18 give more thought and analysis to the nature of these
19 patients and the potential impact. I don't want to either
20 disadvantage the hospital, nor do I want to create an
21 incentive for more fracturing. So I would support your
22 desire to get more information and make a decision, but
23 for what it's worth, simply say that there is concern.
24 That we are trying to understand it, and let folks know

1 that what we don't want to see is this unbundling. And
2 we're going to be looking very closely at exactly who
3 these patients are, what it is that's being done, what is
4 the problem they're trying to solve and is the right way
5 to solve it.

6 DR. NEWHOUSE: I don't see how it could fail to
7 be anything but unbundling, because they've been an acute-
8 care hospital. If it hadn't been for the LTCH they would
9 have used some other --

10 MS. BURKE: Of course that's the question which
11 I'm trying to understand, which is what is the problem
12 that they are trying to solve? Is it a function of the
13 payment system that does not adequately acknowledge that
14 there are patients of an acuity level and require
15 resources that we don't currently acknowledge or support?
16 I don't know. LTCHs developed for some reason. They
17 developed in three towns or whatever, and what we now see
18 is this proliferation.

19 I don't want it simply to be taking advantage of
20 a payment system but I want to understand -- the argument
21 that many people that have gone and spent time there
22 suggest that these are really qualitatively different
23 patients that require qualitatively different services. I
24 want to understand how that reality exists, knowing that

1 most of these patients are not treated in LTCHs but in
2 fact are treated in our current hospital structure or
3 nursing home structure. What is it that we need to do
4 going forward that fundamentally takes care of the
5 patient? What is it that we need to do?

6 DR. NEWHOUSE: Which, of course, could be true.

7 MS. BURKE: Absolutely. I'm not assuming that
8 it isn't. But fundamentally what it ought to be is a
9 payment system that takes care of the patient,
10 irrespective of where the patient resides. My concern is
11 I'm not sure I fully understand the difference and whether
12 or not what we've allowed to have happen is in fact to the
13 advantage of the patient. Maybe it is, in which case we
14 ought to do it differently.

15 MR. HACKBARTH: I think you're making important
16 points and they apply both to the freestanding and the
17 hospital-within-hospital, and the gist of what we're doing
18 here is saying that we believe that there ought to be
19 patient and facility criteria to help assure that this
20 expensive mode of care is applied only to a much smaller
21 subset of patients. That would apply in both instances as
22 well.

23 DR. NEWHOUSE: I was going to respond to Jack
24 but I think it's also a response you, because it's clear

1 that the Commission doesn't want to go to a formal
2 recommendation here, but that we should in any event
3 initiate a study here of who is using the hospital-within-
4 the-hospital and whether in fact this reimbursement system
5 fits that group, as opposed to all users of LTCHs.

6 MR. HACKBARTH: Okay, we are well behind
7 schedule so let us turn to the vote. So we have --

8 DR. REISCHAUER: Can I just ask a point of
9 clarification on recommendation A? You used an
10 interesting term, which is Congress and the Secretary
11 should collaborate. Is this something that does not
12 require legislative change?

13 DR. KAPLAN: I don't think we're clear as to
14 exactly what CMS can do without legislative change and
15 what it can't.

16 DR. MILLER: Some of it may. Most of it is
17 probably is administrative, but some of it may and that's
18 what we're trying to do.

19 MR. HACKBARTH: We still may want to just delete
20 the collaborate and just say, the Congress and Secretary
21 should define --

22 DR. KAPLAN: That would be great. We can do
23 that. We've taken the last phrase -- unfortunately I'm
24 not able to revise it right here, but we've taken the last

1 phrase off of here and put an and between medically
2 complex, so that the recommendation would read --

3 MR. DURENBERGER: Can I ask about that? I'm
4 reading this first part as a preamble and the other part
5 as the important part, the criteria and so forth. I'm
6 looking at recommendation A with this third line in it
7 which is, and generally cannot be treated in other
8 settings.

9 MS. RAPHAEL: We took that out.

10 MR. DURENBERGER: Not yet.

11 MR. HACKBARTH: That's the proposal, to take
12 that out.

13 MR. DURENBERGER: My question is whether we
14 should take it out or if there's an alternate.

15 If it stays as cannot be treated in other
16 settings then it draws a very bright line. But as a
17 preamble to getting into the criteria and some of the
18 other problems, it seems to me that if the reality is --
19 and I'm reflecting on my own community where we've had one
20 for 15 years, it's non-profit, it's part of a large health
21 system and everybody refers to it -- are not likely to be
22 -- these are people who are not likely to be treated in
23 other settings who are going into an LTCH.

24 MR. HACKBARTH: The problem is that in large

1 swaths of the U.S., including my part of the country,
2 these institutions don't exist, either variety,
3 freestanding or hospital-within-hospital. So it literally
4 is not true to say that they cannot or should not or
5 primarily not, and that's one of the basic findings of our
6 work.

7 MR. DURENBERGER: I understand that, but I'm
8 back at Sheila's very last point which is the patient.
9 I'm not saying that in your part of the country patients
10 are always getting, these very complex patients are always
11 getting all of the care that they need in one of your
12 regular acute-care hospitals. I'm reflecting only on my
13 own experience which says, a lot of hospitals in my
14 community would prefer to have a long-term care acute
15 hospital, staffed as they are, for certain very complex
16 cases, so they've created one in our community.

17 So I'm trying to express a concern for the
18 patient and the implication that in many places where the
19 long-term acute-care hospital it is because other
20 hospitals and other people in that community have decided
21 it would be better for patients to have this kind of a
22 specialty mix service. I simply want to make that point.
23 Maybe we can't make it without -- I don't have the
24 language to alter that either.

1 MR. SMITH: Dave, isn't the recommendation as
2 modified perfectly consistent with what you just said?
3 Which is really the first point.

4 MR. DURENBERGER: And I might not even be making
5 if we weren't taking it out.

6 DR. KAPLAN: Are you comfortable with getting
7 rid of the collaborate to and have it read, the Congress
8 and the Secretary should define long-term care hospitals
9 by facility and patient criteria that ensure that patients
10 admitted to these facilities are medically complex and
11 have a good chance of improvement. Then go on to,
12 facility-level criteria should characterize this level of
13 care by features such as staffing, patient evaluation and
14 review processes, and mix of patients. Patient-level
15 criteria should identify specific clinical characteristics
16 and treatment modalities.

17 MR. MULLER: On complex, complex can mean many
18 things, so not too much wordsmithing. Are we meaning more
19 complex or do we -- is that the implication here, based on
20 what we're finding, especially going back to this
21 comparison of, at least the way I read table three was
22 these are far more complex patients, otherwise they
23 wouldn't have payment rates at the outlier point, five,
24 six times of the acute rate. So are we saying these have

1 to be more complex than what would be seen in the acute
2 settings or just complex?

3 MR. HACKBARTH: It is a complication. I prefer
4 to leave it the way it is here. If you add the word more
5 then the reader anticipates that we're going to describe
6 the relative, relative to what, in the ensuing paragraph,
7 and we don't have the basis for doing that. So I
8 understand your point but I think it would complicate
9 matters to add more.

10 So draft recommendation A, all opposed?

11 All in favor?

12 Abstentions?

13 Okay, draft recommendation B. I think we can
14 forgo the re-reading of it. All opposed?

15 All in favor?

16 Abstentions?

17 Okay, we are done.

18 Okay, we have a brief public comment period, and
19 since we are well behind schedule and have a lengthy
20 agenda for this afternoon, as always I want you to keep
21 your comments brief and please avoid repeating a prior
22 speaker's comments. I'm also going to ask that we limit
23 comments to the two topics that we discussed this morning,
24 namely the drug implementation issues and long-term care

1 hospitals. Thank you.

2 MR. KALMAN: Hello, my name is Ed Kalman. I'm
3 general counsel for the National Association of Long-term
4 Care Hospitals and I have two comments I would like to
5 make. With regard to slide three which was a
6 comparison of Medicare expenditures to different sites of
7 care, acute hospitals and other post-acute levels of care
8 I'd like to note that the long-term care hospital PPS
9 system has a short-stay policy. That is the standardized
10 is not applicable to all patients. CMS has stated in the
11 preamble to its update rules that that's approximately 50
12 percent of the patients.

13 So therefore, in setting forth Medicare payments
14 to these providers I would think it would be important
15 that the entire payment system be referenced. For acute
16 hospitals payment equals the standardized times the weight
17 and certain other adjustments. For long-term care
18 hospitals that's not the case. It's the standardized
19 amount times the weight and a short-stay policy. So I
20 would hope that you would consider that.

21 My second comment goes to the discussion on
22 rehabilitation which I thought was quite constructive. It
23 is the case that there are long-term care hospitals that
24 are community resources, and this is mostly freestanding

1 long-term care hospitals, that serve rehabilitation
2 patients, both sick rehabilitation patients and
3 comprehensive rehabilitation patients. Disrupting them in
4 their communities could have significant adverse effect on
5 patterns of care. I want to underscore to you so you
6 understand that. That means patterns of care as to
7 crossover patients, because these institutions take care
8 of long-stay patients many times that are on the juncture
9 between Medicare and Medicaid, which is not a very
10 hospitable place to patients. You're going to be
11 discussing that this afternoon.

12 I do think, however, that the notion that these
13 patient should be paid the appropriate rate is extremely
14 important. When you discuss that in that portion of the
15 chapter I would hope you would have some consideration to
16 allowing these facilities to continue and to be paid for
17 these patients and an IRF PPS rate in rehabilitation units
18 within their hospitals, for which there is a need for
19 congressional authority.

20 Otherwise, I'd like to state our association's
21 complete agreement with the notion that there should be
22 clearly-defined criteria. We're very happy that the staff
23 has chosen to reference the QIOs as a vehicle and note
24 that they can get up and running very soon.

1 Thank you very much.

2 MR. LAUGHLIN: Good afternoon, I'm Rod Laughlin.
3 I'm president of Regency Hospital Company in Atlanta,
4 Georgia. We operate 11 hospital-in-hospital LTCH
5 hospitals around the country. I want to address the issue
6 that these patients are routinely treated in the short-
7 term acute-care hospitals.

8 It really gets back to your definition of
9 treatment. I can look, and I do routinely every day when
10 I decide where to look for an opportunity to build a new
11 LTCH hospital, I pull the MedPAR data and I look at all
12 the discharges for Medicare and commercial and everything
13 else, and I look by length of stay and by DRG. There are
14 about 175 different DRGs that an LTCH would typically
15 treat so I can routinely access that data for people who
16 stayed 15 days or more, 20 days or more, and what have
17 you.

18 What I find that's proven true in looking at
19 hundreds of hospitals across America is that 2 percent to
20 3 percent of their med-surg discharges will fall into the
21 175 DRGs that an LTCH could treat, and if you look at 15
22 to 20 days or longer, that group of people will have an
23 average length of stay of between 24 and 26 days. It
24 happens so often using those parameters that it's just

1 amazing.

2 What that means is that depending on the size of
3 the hospital that we're dealing with, there are routinely
4 200 or 300 patients in that hospital that could benefit,
5 apparently, by being in an LTCH, because they have some
6 medical condition, often just simply multisystem failure
7 which is very difficult to treat, that means they don't
8 respond in the short-term hospital.

9 What we have found in the LTCH that makes a
10 difference in the outcome -- and by the way, I'm getting
11 an average of 55 percent to 65 percent of these patients
12 home, I'm sending another 25 percent to SNF or rehab as
13 quickly as they're medically strong enough to go. We are
14 losing 11 percent to 12 percent, which is substantially
15 better than the industry average of about 30 percent, and
16 we're getting those people home because of the nursing
17 hours and the respiratory therapy hours and the
18 multidisciplinary program we're applying.

19 I am delivering, and Mutual will verify the fact
20 that we have the highest case-mix index of the patients in
21 the country. I have hospitals routinely just under the
22 new PPS system treating a 1.4 to a 1.65 case-mix index,
23 which is very, very high. We're selecting the sickest
24 patients we can find from the post-hospital and anybody

1 else who refers in that community, and we're getting a
2 substantial group home. But it's because I deliver eight
3 to 12 nursing hours per patient day. And that's not
4 aides. That's all licensed people -- based on the acuity
5 of the individual patient. I also deliver five hours of
6 respiratory therapy per respiratory day and two hours at
7 PT/OT and speech across the total patient days. We run
8 this program seven days a week. It doesn't slack off on
9 the weekend. We're selecting very, very sick people and
10 we're getting great results.

11 I believe that these criteria are the right
12 direction to go because they will eliminate some abuses
13 that I know very well, being in this industry, in certain
14 LTCH hospitals. The PPS system is also going to eliminate
15 some abuses and change behavior over time in the future.

16 What I would say to you today is, I don't know
17 how you can make these decisions without getting the data
18 on outcomes. Commissioner DeParle said, I would be
19 willing to pay more for better quality. When I started in
20 the LTCH business in 1992, obviously I saw that it was
21 about saving short-term hospitals some money for patients
22 that don't fit their mission, that require things they're
23 not set up to provide. But what I have come to understand
24 is that a properly-run clinical program in an LTCH can get

1 great outcomes for people and give them their lives back.

2 If you just throw money at the short-term acute
3 PPS without requiring a change in the way those hospitals
4 treat these patients, you won't get a difference in the
5 outcome for people. I am in the LTCH business and I'm
6 passionate about it because I've seen people get their
7 lives back that were not responding even though they were
8 in some of the best tertiary care hospitals in America.
9 It's that 2 percent to 3 percent that we need to look at
10 differently and I applaud you for going through the
11 studies to get this information.

12 Thank you.

13 MR. HACKBARTH: Okay, we'll reconvene at 1:30.

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

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1 AFTERNOON SESSION [1:39 p.m.]

2 MR. HACKBARTH: We are currently running about
3 20 minutes behind schedule so we need to pick up the pace
4 just a little bit. Several of the presentations we have
5 this afternoon are basically informational in nature and I
6 hope that we can move through them relatively quickly. I
7 hope the presenters will not interpret that as a lack of
8 interest in what they are presenting but rather just the
9 practicalities of getting done on time.

10 First up this afternoon is a presentation on
11 beneficiary financial resources and financial liability.

12 DR. ZABINSKI: We know that a primary goal of
13 the Medicare program is to improve beneficiaries' access
14 to care and we also know that financial burden due to out-
15 of-pocket spending on health care plays a key role in
16 beneficiaries' ability to access their care. So today I'm
17 going to discuss the current state of beneficiaries'
18 burden due to out-of-pocket spending and also look at
19 whether that burden has been increasing or decreasing, and
20 think about how that burden might change in the future.

21 Before getting into the results of my analysis I
22 think it's important to cover some important points of my
23 method. First of all, throughout my analysis I will
24 define out-of-pocket spending as the sum of out-of-pocket

1 spending on four components: the cost-sharing from
2 Medicare-covered services, the services that are not
3 covered by Medicare, the Medicare Part B premium, and any
4 out-of-pocket premiums on any supplemental insurance that
5 a beneficiary has.

6 Of these four components, non-covered services
7 have the largest share of out-of-pocket, accounting for
8 about 50 percent of the total on average, followed by
9 supplemental insurance premiums which are about 31 percent
10 of the total out-of-pocket spending.

11 I'd like to say a little bit about the data I
12 used. Generally I used two databases in my analysis, the
13 MCBS cost and use file and the consumer expenditure
14 survey, both from 2001. Both are annual databases using
15 beneficiary's out-of-pocket spending over one year. The
16 bulk of my, analysis uses the MCBS, but I did use the
17 consumer expenditure survey, or the CES, for a small part
18 of it.

19 The MCBS is an individual file whereas the CES
20 is a household file. Because of this difference in the
21 two files the results sometimes look a little bit
22 different between the two files so I just thought I'd tell
23 you about that ahead of time.

24 When I used the MCBS I excluded two groups of

1 beneficiaries. First of all, I excluded the
2 institutionalized who are primarily people in nursing
3 homes, and I also excluded beneficiaries who are in
4 Medicare Advantage plans or other managed-care plans in
5 the Medicare program. I excluded the institutionalized
6 because they have no data on supplemental insurance
7 premiums for supplemental insurance that they have, and
8 their expenditure data on prescription drugs in somewhat
9 unreliable.

10 I also excluded beneficiaries in the Medicare
11 Advantage program, or at that time since I was using 2001
12 it was Medicare+Choice. But I excluded them because their
13 health care expenditures tend to be under-reported
14 relative to beneficiaries in the traditional Medicare
15 program.

16 One other thing about the MCBS is it has a
17 general problem of under-reporting of prescription drugs
18 expenditures. But a using a method that I obtained from
19 researchers at CMS I attempted to adjust for this under-
20 reporting.

21 Now a little bit about my analysis when I used
22 the CES. Now that analysis also excludes the
23 institutionalized but that's because the institutionalized
24 are not part of that survey in any way. I did not exclude

1 people who are in Medicare Advantage or any other managed
2 care plans from the CES analysis because, first of all,
3 you can't identify them on that survey. Also I don't
4 think their under-reporting is as much of a problem on the
5 CES as it is in the MCBS.

6 Finally, none of the results I'm going to
7 present today reflect the impact of the recently passed
8 MMA. The data that I have, as I said, were from 2001 and
9 that was well before the MMA was even in existence.

10 Let's turn to my results. First let's look at
11 the current state of burden from out-of-pocket spending
12 for beneficiaries. This uses the MCBS. The most common
13 measure of beneficiary's burden from out-of-pocket
14 spending is beneficiary's annual out-of-pocket spending as
15 a percentage of their income. Using the MCBS I found that
16 the out-of-pocket spending as a percent of income has a
17 mean of 20 percent and that's illustrated by the leftmost
18 bar in this diagram.

19 I think at this point it's important to
20 emphasize two facts. First of all, Medicare pays for over
21 half of beneficiaries' health care cost so beneficiaries'
22 out-of-pocket spending as a percent of income would
23 probably be much higher if Medicare did not exist. Second
24 of all, the mean value of 20 percent I really want to

1 emphasize is only one a number it hides substantial
2 variation in this measure among beneficiaries. For
3 example, we know that 10 percent of beneficiaries spent
4 less than 2 percent of their income on health care, and
5 that's illustrated by the bar for the 10th percentile in
6 the diagram. At the same time, another 10 percent of
7 beneficiaries spend more than 30 percent of income on
8 health care and that's illustrated by the 90th percentile
9 bar on the diagram to the very right.

10 Another issue regarding the mean of 20 percent
11 is that it may be a little bit misleading measure of the
12 burden for what you might call the typical beneficiary.
13 For example, in this diagram we show a value of about 10
14 percent at the median or the 50th percentile. What that
15 tells us is that half the beneficiaries actually less than
16 10 percent of their income on health care despite the
17 average being 20 percent.

18 A relationship that has been frequently analyzed
19 by researchers is the correlation between beneficiary's
20 income and their burden from out-of-pocket spending. On
21 this figure we show that as beneficiary's income increases
22 in relation to the poverty line their out-of-pocket
23 spending as a percentage of income tends to decline. For
24 example, out-of-pocket spending as percentage of income

1 has an average of 45 percent among beneficiaries who are
2 below the poverty line but an average of only 7 percent
3 among beneficiaries with income greater than 400 percent
4 of the poverty line. Now I'd like to turn to the
5 concept of whether burden from out-of-pocket spending has
6 increased among beneficiaries. This analysis consisted of
7 looking at elderly households from the 1981, 1991, and
8 2001 consumer expenditure survey where I define an elderly
9 household as a household has at least one member age 65 or
10 older. The analysis excludes the disabled under-65
11 beneficiaries because you can't identify such
12 beneficiaries on the consumer expenditure survey and
13 that's why I only worked with the elderly.

14 The results of my analysis are kind
15 indefinite. I definitely can't determine whether the
16 burden of out-of-pocket spending has increased or
17 decreased. The answer depends on how you measure burden.
18 For example, if we again use the measure of burden from
19 the previous two slides, that being out-of-pocket spending
20 as a percent of income, it appears that burden has
21 increased substantially over the timeframe we're looking
22 at, 1981 to 2001. Basically I found that the mean of this
23 measure increased from 15 percent in 1981 to 26 percent in
24 2001 among the elderly households.

1 But using an alternative measure of burden in
2 household income net of out-of-pocket spending I get a
3 very different result. What this measure indicates is
4 household income that is available to pay for goods and
5 services after the household has paid for their health
6 care. I found this measure stayed nearly constant in real
7 terms from 1981 to 2001 lying in the \$22,000 to \$23,000
8 range in 2001 dollars. What this suggests is that burden
9 from out-of-pocket spending has changed very little over
10 this timeframe.

11 The reason we have these seemingly conflicting
12 results from the previous slide versus this slide is that
13 on the previous slide it reflects the fact that income
14 increased by a slower rate or a smaller percentage than
15 did out-of-pocket spending, while in this slide we reflect
16 the fact that income increased by a greater magnitude than
17 out-of-pocket spending even though income increased at a
18 slower rate.

19 Next I'd like to consider how the burden from
20 out-of-pocket spending may change in the future. I've
21 identified two key factors that would likely affect
22 beneficiaries' burden from out-of-pocket spending in the
23 coming years. One is a decline in the prevalence, or at
24 least the potential decline in the prevalence of employer-

1 sponsored insurance or ESI as a source of coverage to
2 supplement Medicare. Such a decline will likely increase
3 the overall out-of-pocket spending because ESI tends to be
4 a relatively generous form of supplemental insurance.

5 The other factor is the prescription drug
6 benefit in the MMA which should decrease out-of-pocket
7 spending in the aggregate.

8 First let's look at the decline in the
9 prevalence of employer-sponsored insurance. On the MCBS
10 it shows that typically the decline in the availability of
11 employer-sponsored insurance actually has been quite small
12 amongst current beneficiaries. In this case I emphasize
13 I'm talking about current beneficiaries. For example, the
14 prevalence of ESI has dropped the most among beneficiaries
15 age 65 to 74, yet the percentage in that age group with
16 ESI decreased by only three points from 39 percent in 1993
17 to 36 percent in 2001.

18 However, other data show that a decline in the
19 availability of ESI is likely to be a much larger problem
20 among future retirees or people who have yet to enter
21 Medicare. A survey by the Kaiser Family Foundation
22 indicates that in 2003 10 percent of large firms that are
23 defined as firms with at least 1,000 employees dropped
24 coverage for future retirees. Moreover, 20 percent of

1 those large firms said they are least somewhat likely to
2 drop coverage for future retirees over the next three
3 years.

4 In addition, the percentage of people working in
5 large firms is declining as well. That's an important
6 fact because large firms are much more likely to offer ESI
7 to retirees than are small firms so this trend will also
8 reduce the number of beneficiaries with employer-sponsored
9 insurance as a form of supplemental coverage.

10 Now you may be wondering what's so important
11 about this decline or this potential decline in ESI. The
12 issue is that ESI is, on average, the most generous and
13 the most common form of supplemental insurance with 33
14 percent of beneficiaries having that type of
15 supplementation. However, if the survey from the Kaiser
16 Family Foundation is any indication it may no longer be
17 the most common form of supplemental coverage in the
18 future.

19 Now alternatives to having ESI as a form of
20 supplementation include purchasing a Medigap plan, which
21 is currently the option chosen by 28 percent of
22 beneficiaries, or one can enroll in a Medicare Advantage
23 or other managed-care option which at the time of the data
24 that I have 16 percent of beneficiaries held, or a

1 beneficiary could go without supplemental coverage which
2 is the status of 9 percent of beneficiaries. The key
3 point is that having some of these options in lieu of ESI
4 will likely result in higher out-of-pocket spending and
5 could potentially affect their access to care.

6 Now let's consider the drug benefit under the
7 MMA that will begin at 2006. The drug benefit will
8 increase out-of-pocket spending for some beneficiaries but
9 decrease it for others and on net should reduce
10 beneficiaries' out-of-pocket spending in the aggregate.
11 To get a strong understanding of how the drug benefit
12 could affect out-of-pocket spending we should get an
13 understanding of the cost sharing for which the
14 beneficiary is responsible under the standard benefit.

15 On this slide I think it's easiest to work from
16 the bottom up here. At the very bottom we have the annual
17 premium of \$420 in 2006 as estimated by CBO. Working up
18 the diagram, the drug benefit has a deductible of \$250.
19 Then if a beneficiary's drug expenditures go above \$250
20 the drug benefit bill pay 75 percent of the expenditures
21 with a beneficiary facing a coinsurance of 25 percent.
22 This lasts until the total expenditures on drugs reach a
23 coverage limit of \$2,250. Then if combined drug spending
24 by a beneficiary in a program exceeds \$2,250, the

1 beneficiary is then solely responsible for the next \$2,850
2 in drug spending until reaching a catastrophic limit of
3 \$5,100. At that point the beneficiary would have \$3,600
4 in out-of-pocket spending on drugs plus \$420 for the
5 premium. Finally, for drug expenditures beyond a
6 catastrophic limit the program pays 95 percent of cost
7 with the beneficiary paying the remainder.

8 Then to end my presentation I'd like to
9 summarize result of my analysis of the impact that
10 demographic characteristics can have on beneficiary's
11 burden due to out-of-pocket spending. A motivation for
12 this part of the analysis was that we were asked to
13 examine the impact that demographics can have on out-of-
14 pocket spending. The analysis consisted of comparing the
15 burden of out-of-pocket spending for groups of
16 beneficiaries who have the same characteristics with one
17 key characteristic being different. For example, I
18 compared men age 65 to 69 who have ESI or employer-
19 sponsored insurance to women who are age 65 to 69 who also
20 have ESI. This comparison allows us to get at least a
21 sense of the impact that gender can have on the burden of
22 out-of-pocket spending. Using similar analyses I also
23 examined the impact that supplemental coverage, marital
24 status, and age can have on burden. For each comparison I

1 made I measured burden with two variables that I used in
2 this discussion. One is the out-of-pocket spending as a
3 percentage of income, and the other is income net of out-
4 of-pocket spending.

5 The results of my analysis revealed greater
6 burden from out-of-pocket spending if a beneficiary is
7 unmarried rather than marries, is a woman rather than a
8 man, is older rather than younger, and has Medigap rather
9 than ESI. In general the results were driven more by
10 differences in income rather than differences in out-of-
11 pocket spending. That is, characteristics that reflect
12 relatively high burdens of out-of-pocket also tend to
13 reflect relatively low incomes.

14 To close I'd like to say that this work is
15 intended as an appendix to the June report. The purpose
16 of the work is to compile a database that will allow
17 MedPAC staff the capability to quickly examine the impacts
18 of things like policy changes and to perform other
19 analyses similar to this one.

20 MS. ROSENBLATT: I thought this was excellent.
21 There's one thing, if it's possible to add to the chapter
22 for the June report, the figure B-2 that you showed, out-
23 of-pocket spending varying with the mean of 20 percent and
24 then in the 90th, the highest people spending about 35

1 percent. You have a very interesting paragraph in there.
2 You say, the average may not even provide a meaningful
3 representation of the typical beneficiary. The average of
4 20 percent is twice as large as the median value of 10
5 percent.

6 Using the Jack Rowe rule that most people look
7 only at the graphs, would it be possible to have a graph
8 that takes out the extreme and looks at it from that
9 perspective? I'm just thinking that because the mean is
10 so different than the median, people who just look at the
11 graphs are going to get walk away it's a 20 percent
12 number. If we can avoid that I think that would be
13 beneficial.

14 DR. ROWE: With respect to the emphasis on
15 employee-sponsored insurance, which I think is
16 appropriate, I have a sense that you may -- some of these
17 data may exaggerate the number of Medicare beneficiaries
18 who are retired who actually have ESI. You might want to
19 consider the distinction between an employer offering
20 insurance to retirees and an employer who just offers
21 access to the network discounts that are in the plan for
22 their active employees because does not subsidize the
23 payment at all.

24 So that what happens is an employer might have a

1 full policy for their retirees and their retirees might
2 pay some portion of the premium and the costs are covered.
3 Then the employer says, I can't afford that anymore so
4 here's what I'm going to do. I'm not going to give you
5 insurance anymore, but we are going to give the lower
6 rates that we get that Aetna, who is our insurer, or
7 Wellpoint who's our insurer, has negotiated with the
8 network, with the physicians and the hospitals or the
9 pharmacy for that matter for the cost of the medicine. So
10 you get to buy at the discounted rate but you have to pay
11 the whole thing yourself.

12 Those people don't have insurance. You say that
13 they have employer-sponsored insurance, ESI. They are not
14 insured. They are paying everything out of their own
15 pocket, but they have a discount. If you look at what's
16 happening I believe a large proportion of employers are
17 going to route.

18 DR. ZABINSKI: I think that's correct, yes.

19 DR. ROWE: When you call them and you say, do
20 you have a retirement health benefit, their answer would
21 be yes. But they really are not insuring their retirees
22 and they're not paying anything out of the company.

23 So that definition, it might be worth going back
24 to Kaiser and asking them if they differentiated, or

1 making some statement about that.

2 DR. ZABINSKI: Just about that, the information
3 I have about who's got employer-sponsored insurance,
4 that's from the MCBS. As far as whether there in a
5 circumstance that you describe where the beneficiary is
6 paying the entire premium you can't really tease it out
7 fully. But the Kaiser Family Foundation study that I
8 cited in a little bit different context also talks about
9 this trend towards having a beneficiary pay the entire
10 premium and I think we can mention that. I think that
11 would be a real good idea.

12 MR. SMITH: Just very briefly. I wonder if we
13 know anything about expenditures that don't get made. The
14 next step here it would seem to me is, given the burden
15 and whether it's growing or not -- I understand we don't
16 know, but the distribution of the burden particularly as
17 it affects particularly low-income beneficiaries would
18 suggest or at least cause one to wonder whether or not
19 there are expenditures that aren't being made. Part of
20 looking at financial liability and the adequacy of the
21 system in terms of what it tosses onto beneficiaries is
22 trying to get a handle on foregone expenditures,
23 expenditures that don't happen that should.

24 DR. ZABINSKI: Basically saying people that

1 should get care but don't?

2 MR. SMITH: Right. One of the things that Joan
3 old us this morning thinking about getting ready for the
4 drug benefit is, in some circumstances, confronted with a
5 higher tier copay associated with a drug, the expenditure
6 doesn't get made at all. That's an important piece of
7 this puzzle. I'm sure we can't do it by the June report
8 but it would be important in terms of understanding this
9 burden to get an understanding of what the burden for
10 medically-appropriate expenditures looks like and then
11 figure out how much of that gets made.

12 DR. REISCHAUER: If we had that, we would have
13 the answer to a lot of other questions.

14 MR. SMITH: It's not a trivial question or an
15 easy one.

16 DR. NEWHOUSE: I have a suggestion for another
17 chart or analysis that you may or may not be able to do in
18 time for the June report. You followed the customary
19 tradition of measuring annual out-of-pocket spending
20 relative to annual income. That seems to me to be
21 reasonably useful for someone who is cash-flow
22 constrained, which would be not atypical in this
23 population. But for a burden calculation it seems to me
24 something on a longer-term basis is better because large

1 out-of-pocket medical doesn't necessarily happen every
2 year. I think the MCBS has some kind of rotating panel,
3 right?

4 DR. ZABINSKI: Right, basically one-third of the
5 panel is new every year. People are in three years.

6 DR. NEWHOUSE: So I wonder if you could do a
7 three-year analysis with what you're showing as percentage
8 of spending as a percentage of income and so on for a
9 three-year period instead of a one-year period to see how
10 much of the skewness flattened out.

11 DR. ZABINSKI: Just a few thoughts on that. I
12 really like the idea of doing multiple years is something
13 that I think is a great idea. I have one concern about
14 sample size. If you work with three years of data you'll
15 end up with a sample of about 3,000 which for the entire
16 group is fine. But if you start cutting into groups, I
17 worry a little bit, like eight women 65 to 69 who have
18 employer-sponsored insurance.

19 DR. NEWHOUSE: Either give it to me for the
20 whole 3,000 or pool a couple years, pool a couple three-
21 year samples.

22 DR. ZABINSKI: All right. I see what you mean.
23 My other concern, maybe I'm confused about it right now
24 and it's not as difficult as I think, but how to handle

1 people who switch categories. People age and they start
2 in the 65 to 69 group in the first year, but then they
3 turn 70 halfway through your three-year cycle, how does
4 one classify them?

5 DR. NEWHOUSE: Adopt some convention, starting
6 age or middle year age or something.

7 DR. ZABINSKI: I like the idea though.

8 DR. REISCHAUER: Dan, you mentioned at the
9 beginning that the data here is not particularly good.
10 Remind me what fraction of income is actually reported, 60
11 percent, 50 percent?

12 DR. ZABINSKI: I worked with somebody at CBO who
13 shall remain nameless, but by his estimate it looks to be
14 more like -- at least when he compared it to the current
15 population survey, using that as a benchmark it's 12
16 percent, 13 percent too low.

17 DR. REISCHAUER: But the CPS is low too.

18 DR. ZABINSKI: Probably.

19 DR. REISCHAUER: I'm not criticizing it, it's
20 just I would make a little bit more out of that.

21 Another thing I was really surprised about, and
22 I look forward to aging here, in the sense that you said
23 the CIP discovered that 9 percent of people in the CIP had
24 assets over \$1 million.

1 DR. ZABINSKI: So you think that's a lot? My
2 take was that's not very many.

3 DR. REISCHAUER: It depends on what we're
4 counting. If we're counting pension assets, particularly
5 in a defined benefit, a capitalized value of a defined
6 benefit plan it probably isn't.

7 DR. ZABINSKI: No, my understanding is that's
8 not in there. Let me tell you why I think it's low, or my
9 initial take was that it's low is that all these experts
10 on retirement say you should have \$1 million in assets
11 when you retire to retire comfortably, and if only 9
12 percent of people are there, we're all in trouble.

13 DR. REISCHAUER: But those same experts say,
14 most of you are going to be miserable. Should and are are
15 two different things.

16 The other question I had is, on some of these
17 what we do about dividing income and assets among the
18 spouses? Because the medical expenditures you clearly can
19 associate with an individual. The resources that that
20 family unit has you can't. When you go to some of these
21 later tables where you were looking at ESI versus Medigap
22 I was wondering whether what I was looking at was pure or
23 the ESI applied to a couple, some individuals and some
24 couples mixed together. Whereas, the Medigap we know

1 applies only to an individual.

2 DR. ZABINSKI: If I follow what you're talking
3 about, first of all, at the beginning I talk about assets,
4 just talk about beneficiary's asset situation. But
5 throughout the analysis I strictly rely on out-of-pocket
6 spending relative to income.

7 DR. REISCHAUER: How do we do the income for a
8 couple?

9 DR. ZABINSKI: What I did was, on the MCBS
10 spending is recorded at the individual level. Now if
11 somebody lives alone their income is also at an individual
12 level. Now if they're married they report joint income
13 with the spouse. What I did in that case is I divided the
14 income by 1.26. You're asking, where did he come up with
15 that?

16 DR. REISCHAUER: No, that's fine.

17 DR. ZABINSKI: I'll stop there then.

18 MS. RAPHAEL: I have a question on form. What
19 determines if something goes into the appendix or becomes
20 a full-fledged chapter in our June report?

21 DR. MILLER: On this one, there's actually a
22 couple things that you've seen in the last year. We did a
23 set of charts on a question that had come up on PLI -- I
24 can't remember -- and we came through and had a set of

1 pictures to try and answer that question. There is some
2 push to do some more of that. Instead of long dispositive
3 chapters, that kind of thing, when you have an issue that
4 lends itself to data, trying to do some of that.

5 That coupled with the fact that we're just
6 breaking ground on this, we're not really talking about
7 what we're doing. We're just painting a picture in then
8 it's really building a database to go forward, pushed us
9 to an appendix on this.

10 MR. HACKBARTH: This seems different in
11 character. It's strictly descriptive. Most of our
12 chapters, if they don't make policy recommendations, they
13 go more into the policy issues. Here it's really strictly
14 descriptive data.

15 DR. WOLTER: This is a little different line of
16 question and it's not the intent of this chapter and
17 perhaps it's already been done, but it would be
18 interesting just to the see a summary of how policy
19 affects this in terms of the percentage of out-of-pocket
20 against the total charge; rural-urban, geographic
21 variation, inpatient care, outpatient care, physician
22 care. Because it seems to me from the data we've looked
23 at over the last year or two that, for example, out-of-
24 pocket spending in hospital outpatient I believe, as a

1 percentage, is higher than inpatient. I may not be
2 remembering that right. But it would just be interesting
3 to put a little package of that together. It might
4 influence how one thinks about policy and out-of-pocket
5 spending in the different sectors.

6 MR. HACKBARTH: Okay, thank you very much, Dan.

7 Next is dual eligible beneficiaries.

8 MS. MUTTI: This presentation will focus on
9 several new analyses that we've done on dual eligibles.
10 This complements the work that we've done earlier and will
11 be part of a chapter, a draft of which you've received.
12 We're adding these new analyses. One will be more
13 detailed findings on the composition of the dual
14 population and their spending patterns. Another one that
15 Susanne will present on is how long have duals been duals.
16 And a third one is our analysis of dual beneficiaries'
17 access to care. While Dan is not initially presenting any
18 information here he is available to answer questions
19 because he did much of the work on the spending and
20 composition of the dual population. In the future we
21 hope to follow up on this work, looking particularly at
22 the quality of care for dual beneficiaries. I know that
23 was an interest of at least one member of the commission.
24 We'd also like to look at policy options to improve their

1 access and quality and cost-effectiveness of their care.
2 At the end of the presentation we look forward to hearing
3 your comments not only on this material which we plan to
4 incorporate in the chapter but also the whole chapter
5 altogether.

6 As we discussed last month the dual population
7 is not demographically homogenous, nor is it all equally
8 costly to the Medicare program. As with non-dual
9 spending, it's concentrated in a minority of
10 beneficiaries. To get an understanding of the composition
11 and the spending patterns of the population we divided the
12 population into six subgroups, three under disabled and
13 the same three categories under aged. We also aggregated
14 the three categories for disabled as well as aged so you
15 actually see eight lines of data there. Let me give
16 credit, this work builds on stuff that Chris Hogan and
17 Sandy Foot has done with respect to the disabled
18 population.

19 A couple words about our method. First we
20 pulled MCBS data over two sets of three years. This was
21 to allow a sufficient sample for us to cut it as finely as
22 this analysis required. Then we aside the beneficiaries
23 to categories using a hierarchy. So that if people had
24 mental or cognitive problems they were assigned to the

1 mental and cognitive subgroups regardless of whether they
2 had difficulties with ADLs. So some of those people in
3 the mental and cognitive category definitely have problems
4 with activities of daily living. For those people
5 assigned to the other categories, they do not have mental
6 or cognitive problems as we measured it.

7 We identified people with mental and cognitive
8 problems through a combination of survey responses,
9 diagnosis information on claims, and prescription drug
10 use. We sought to count only those who have serious
11 mental illness including dementia and mental retardation.
12 We did not try to capture people with depression only in
13 this analysis. When assigning beneficiaries to a category
14 based on limitations in activities of daily living we used
15 survey results only.

16 As with our earlier analysis we found that just
17 over one-third of the duals are disabled and under 65;
18 about two-thirds are aged. Of the disabled, about half
19 have mental or cognitive problems. Of the aged, about
20 one-third have mental and cognitive problems. Perhaps
21 surprisingly, just less than half of the aged duals have
22 difficulty with less than two ADLs. The composition of
23 duals has changed somewhat over the last few years. The
24 proportion of duals under 65 and disabled has increased

1 from 28 percent to 34 percent. This appears roughly
2 commensurate with the increase in the population of
3 disabled overall in the Medicare population. There's also
4 been a small increase in the portion of duals, aged and
5 disabled combined, that are mentally and cognitively
6 disabled.

7 By looking at aged and disabled dual
8 beneficiaries together we can summarize our findings in
9 another way; 39 percent have mental or cognitive
10 limitations, 20 percent have difficult with two or more
11 ADLs but do not have cognitive or mental problems, and
12 over 40 percent have difficulty with less than two ADLs,
13 but again, don't have mental or cognitive problems.

14 On this slide we look at Medicare spending
15 levels by subgroup and compare them to non-duals with the
16 same characters in the 1999-2001 time period. It is
17 important to focus on the fact that here we're just
18 presenting the Medicare spending totals, not total
19 spending for the beneficiaries which would also include
20 Medicaid spending and out-of-pocket spending. We find
21 that the most costly group of duals here is the aged with
22 mental and cognitive limitations, and then next comes the
23 age with difficulties with two or more ADLs. The disabled
24 overall are less costly to Medicare than the aged. And

1 certainly the least costly groups are those with
2 difficulties with less than two ADLs.

3 When comparing Medicare spending for duals to
4 non-duals, the disabled are statistically significantly
5 different than their non-dual counterparts. However,
6 Medicare spending on aged duals is not statistically
7 significantly different than spending for non-duals in any
8 of those subgroups, and the asterisks indicate the
9 statistical significance on the slide there.

10 The similarity in Medicare spending for aged
11 duals and non-duals should not mask the differences in
12 total cost between the two populations however because the
13 aged duals are more likely to be in nursing homes than
14 aged non-duals, much of their spending is reflected in
15 Medicaid spending and that's just not shown here.

16 We also took a look at how Medicare spending is
17 distributed by service for duals compared to non-duals.
18 For this analysis we just looked at those living in the
19 community. On this chart the numbers reflect the percent
20 of Medicare spending on each of the selected service. As
21 you can see, the bulk of spending for both duals and non-
22 duals is for hospital inpatient and physician care. I
23 don't think that's very surprising. But we do see a few
24 statistically significant differences between the two

1 groups, as indicated by the asterisks.

2 First, a greater proportionate of Medicare
3 spending is devoted to home health care for duals than
4 non-duals. And second, a great portion of spending is
5 devoted to both physician and SNF care for non-duals as
6 compared to duals.

7 This chart builds on the last one by adding two
8 columns with data from the 1993 to 1995 period. This
9 comparison allows assess us to see if there's been a
10 change in spending patterns, and if there has been, is it
11 consistent across both duals and non-duals, or does it
12 just apply to one group. The asterisks here indicate
13 statistically significant differences across the time
14 period. So we can see for non-duals, the portion devoted
15 to each service category changed. The portion spent on
16 hospital and home health care declined, while the portion
17 spent on physician, OPD, and SNF care went up.

18 Just to be sure you're following me here, for
19 example, on hospital care in the '93 to '95 period, the
20 non-duals hospital care had a portion of about 52.2
21 percent of their total Medicare spending. By '99 to '01
22 it declined to 49.1 percent. Spending for duals changed
23 also. As with non-duals, there was a decline in the
24 portion spent on home health and in increase in the

1 portion spent on physician and OPD care. There was no
2 statistically significant change in the portion spent on
3 SNF or inpatient care.

4 With that, let me turn it over to Susanne.

5 DR. SEAGRAVE: In response to a question from
6 the Commission we analyzed the length of time dual
7 eligible beneficiaries tend to remain on Medicaid. It is
8 important for policymakers to understand the length of
9 time beneficiaries remain on Medicaid because it affects
10 whether, and if so how, they might want to consider
11 tailoring policies such as policies that encourage care
12 management to this particular population. A couple of
13 caveats to note about this data. First, the data likely
14 under-represents the medically needy dual eligibles as
15 these beneficiaries are much more difficult to identify in
16 administrative data. The other thing to note is that we
17 included beneficiaries who had gaps in their Medicaid
18 coverage in this, because the question that we were
19 interested in looking at was how long in total people
20 tended to remain on care. But the people who had gaps
21 were in the minority in this data.

22 We found that dually eligible beneficiaries
23 tended to remain on Medicaid for relatively long periods
24 of time. This chart include Medicare beneficiaries who

1 first became eligible for Medicaid in 1994, 1995 or 1996,
2 and we have data on these people through 2002. The total
3 height of the first bar represents those people on
4 Medicaid for less than or equal to one year. The second
5 bar represents those on Medicaid for between one and two
6 years and so on. The yellow sections on the top of the
7 bars indicates the percentage of these beneficiaries who
8 died in each of the time periods.

9 As you can see from the bar on the far right, a
10 full 47 percent of these beneficiaries stayed on Medicaid
11 for six to nine years, or through the end of 2002. I
12 should note that some of these beneficiaries could have
13 kept going on Medicaid past the period we were able to
14 observe.

15 Conversely, only about 14 percent of these
16 beneficiaries are in the bar on the far left, indicating
17 that they were on Medicaid for one year or less. Of this
18 14 percent, about 40 percent of those died in the first
19 year.

20 This analysis suggests that policymakers should
21 keep in mind that dual eligibles tend to stay on Medicaid
22 for relatively long periods of time, when designing
23 policies targeted to this population. For example, these
24 results may make care management options more meaningful

1 for this population.

2 Sarah Lowery will now discuss our findings
3 regarding duals' access to care.

4 MS. LOWERY: Are dual eligibles able to access
5 to health care they need? This question is particularly
6 relevant for this population because, one, they exhibit
7 characteristics associated with needing care, like they
8 have limitations in activity of daily living, as well as
9 they rate their health status poorly. And two, they often
10 have characteristics that may hinder their ability to
11 obtain care; for example, they are often poor and poorly
12 educated.

13 One way to measure beneficiaries' access to care
14 is by asking beneficiaries themselves to rate their access
15 to care. Two surveys that do this are the CAHPS, the
16 Consumer Assessment of Health Plan Survey, and the MCBS,
17 both of which are administered by CMS. Results from these
18 surveys in 2001 show that most duals report good access to
19 health care. Of the questions that we analyzed, between
20 75 percent and 93 percent of dual eligible beneficiaries
21 highly rate their access to care.

22 Medicare beneficiaries with other sources of
23 supplemental coverage, such as employer-sponsored coverage
24 or Medigap, rate their access to care more highly than

1 duals however. The exception to this is beneficiaries
2 with other sources of public supplemental insurance, such
3 as that from the Department of Veterans Affairs. These
4 beneficiaries do not rate their care as statistically
5 different than duals.

6 Beneficiaries without supplemental insurance,
7 those with just Medicare. defined as Medicare-only
8 beneficiaries, may or may not report better access to care
9 than dual eligibles. Results depend on the access of care
10 that is measured.

11 Now we'll look at these measures.

12 When asked if they had a usual source of care
13 like a particular clinic, doctor, or nurse duals respond
14 yes more often than Medicare-only beneficiaries. Duals
15 access to personal doctors, nurses, or facilities appears
16 to be good. Duals also report that they delay care due to
17 cost less often than Medicare-only beneficiaries.

18 Intuitively, this make sense since duals have little out-
19 of-pocket liability. The majority have Medicaid coverage
20 for services that Medicare does not cover and for cost-
21 sharing associated with Medicare-covered benefits.

22 In response to questions asking how often they
23 got immediate care when needed or got a prompt routine
24 health care appointment, Medicare-only beneficiaries

1 responded usually or always more often than duals. This
2 suggests that duals may have slightly more problems
3 accessing both immediate and routine care than do
4 beneficiaries with only Medicare. These differences are
5 statistically significant but are not very great, as you
6 can see from the slide.

7 When asked the broad, overarching question of
8 whether the beneficiary had any problem getting necessary
9 care we find conflicting results. This question to asked
10 on both surveys and on the MCBS we find no difference
11 between duals and Medicare-only beneficiaries responses.
12 However, on CAHPS duals report that they have slightly
13 more problems getting necessary health care than Medicare-
14 only beneficiaries. Both duals and Medicare-only
15 beneficiaries appear able to see a specialist when needed
16 and both groups appear satisfied with their personal
17 doctor, specialist and overall health care.

18 So overall when compared with Medicare-only
19 beneficiaries duals have a slightly more difficult time
20 accessing immediate and regular care, but they are more
21 likely to have a usual source of care and less likely to
22 delay care due to cost. Again, these differences are
23 statistically significant but are generally small. Both
24 groups rate their health care and providers highly.

1 It's important to keep in mind that both MCBS
2 and CAHPS are beneficiary satisfaction surveys, which can
3 be biased and influenced by factors such as socioeconomic
4 status and education levels. For example, one bias that
5 can affect survey responses is the tendency of respondents
6 to answer in a way that they perceive to be consistent
7 with societal norms rather than based on their own
8 personal experience. Studies have shown that survey
9 participants with lower income or education levels exhibit
10 biases such as this, and therefore these demographic
11 groups satisfaction with their access to health care may
12 be overestimated. It is important to keep this in mind
13 for duals in particular because they are poorer by
14 definition and may often have lower education levels.

15 Another limitation of only analyzing survey data
16 to determine whether beneficiaries have good access to
17 health care is that these datasets are unable to describe
18 whether beneficiaries received appropriate health care.
19 We plan to look into this further, together with our work
20 on quality.

21 Now we welcome your comments on this
22 presentation and the draft chapter.

23 MR. HACKBARTH: Any questions or comments?

24 DR. REISCHAUER: The first few pages where you

1 are trying to lay out who's eligible for what I thought I
2 understood until I read this. It's even more complicated
3 than I thought, and I think you made it even more
4 complicated than I now think it is, in the sense that what
5 most people are interested in is the what, and then the
6 who. By the what, they're the full dual eligibles, and
7 there are a required budget and then there's an optional
8 bunch. I don't know if the people between 73 percent and
9 100 percent of poverty which at state option can receive
10 full dual, whether the state without a waiver can offer a
11 more limited benefit package for those folks than to
12 others. I don't think so. I know the medically needy
13 they can, but I don't think they can for them.

14 But you make it sound like these guys are really
15 QMBs that some states are deciding to give something else
16 to, whereas, there's the required dual eligible folks, 73
17 percent of poverty and below, states have the option to
18 expand that up to 100 percent of poverty and a number of
19 states have. Then there's the QMBs, which federal law
20 requires everybody below 100 percent to get it, and the
21 SLIMBs, et cetera. I have a suggestion for maybe how to
22 arrange the chart, if you think it makes sense.

23 I then had a question about the mental health
24 payment rates. This is on page 24. In scenario A, is it

1 true that if the Medicaid rate is \$50, Medicaid has to pay
2 \$12.50, but if the Medicaid payment rate is \$49.99 it pays
3 zero? Because I thought Medicaid didn't have to pay
4 anything over it's own payment rate.

5 MS. MUTTI: Actually let me spend a moment
6 thinking about that and I'll clarify that.

7 DR. WAKEFIELD: Is the PACE program just for
8 dual eligibles or were you just taking about it when it's
9 applied to dual eligibles? I couldn't tell. It's
10 discussed on page 32.

11 MS. THOMAS: In order to participate in PACE you
12 have to be Medicare or Medicaid. You don't have to be
13 both but most people are, and there are processes to get
14 capitation payments from each program. But if you're only
15 Medicare, of course there's only a Medicare. If you're
16 only Medicaid, there's only Medicaid. But typically, 95
17 percent of the folks in PACE are dual.

18 DR. REISCHAUER: In that complex chart, table
19 two, under the ADLs the dual thing doesn't add to 100.

20 MS. MUTTI: I caught today too. It's supposed
21 to be 45 percent on the first one.

22 DR. REISCHAUER: Then I would, the first time
23 you mention the word Medicaid I would put parentheses or a
24 comma, means-tested program. It isn't till about page

1 seven that you say that, and I think it brings more
2 understanding to some of the things you're saying about
3 income levels and other things early on.

4 MR. HACKBARTH: Thanks.

5 Next is purchasing strategies.

6 MS. MUTTI: Last month we presented our work
7 plan and summary findings for our draft purchasing
8 strategies chapter. As you may recall, the purpose of
9 this effort is to explore the range of strategies that
10 private purchasers and other governmental purchasers may
11 be sing to improve the efficiency of health care delivery.
12 Our thought here is that this experience may provide ideas
13 for the management of the Medicare fee-for-service
14 program.

15 Since the last meeting we have revised our
16 findings, incorporating your comments as well as
17 additional research. We have also added to the chapter a
18 discussion focusing on the strategies used by the private
19 sector to address concerns about the appropriateness and
20 quality of imaging services. This includes a brief
21 assessment of the extent to which the federal government
22 is using similar strategies. Kevin will provide further
23 detail on that in a moment.

24 Our final new part of the draft raises several

1 of the fundamental issues that must be addressed if these
2 strategies are considered for fee-for-service Medicare,
3 and Jill say that a bit about this. First, let me just
4 turn it over to Kevin though and say that we look forward
5 to getting your comments on the chapter as a whole at the
6 conclusion.

7 DR. HAYES: We'll talk now about the imaging
8 section of the chapter. One way to think about it is as a
9 kind of case study. It gave us an opportunity focus in on
10 a particular type of service, provide some additional
11 detail on private insurers' purchasing strategies. The
12 other thing it allowed us to do was to look for parallels
13 or similarities between the strategies of private insurers
14 and current activities of the federal government, either
15 on the part of CMS or in the case of, as we'll get to in a
16 minute, mammography facilities of the Food and Drug
17 Administration.

18 So why imaging services otherwise? First off,
19 we have the matter of last year's June report. Recall
20 that we had a chapter there on growth and variation in the
21 use of physician services. One type of service we paid
22 particular attention to was imaging. It was a case where
23 we found quite a bit of variation geographically in use of
24 the services, and it raised questions, as other research

1 has done, about whether there is some overuse of these
2 services.

3 The other reason to consider imaging services
4 from a purchasing strategies standpoint has to do with the
5 panel that we had at last month's meeting. From a staff
6 standpoint our perception was that the panel generated a
7 fair amount of discussion among commissioners and was
8 overall well-received, so we wanted to try to summarize
9 what the panelists said and then, as I say, link that to
10 current federal policy.

11 So the next part of our plan here for this
12 chapter is to just to summarize what we heard from the
13 panelists. In general we can see that they talked about a
14 number of different strategies. It's useful I think to
15 categorize them into two groups. We have the first three
16 strategies profiling, preauthorization, beneficiary
17 education. These were strategies that we heard about
18 otherwise in interviews with health plan executives. One
19 way to perceive what the panelists said was that it wasn't
20 anything particularly unique about imaging services with
21 respect to these strategies.

22 On the other hand, the last three, the safety
23 standards, privileging, and coding edits did come across
24 as having been honed a fair amount to focus in on

1 particular issues surrounding imaging services. They
2 really were intended to address half a dozen or so
3 different problems that the private insurers had
4 identified in the market areas where they are operating.
5 They include such things as proliferation of imaging
6 equipment, lack of familiarity with new imaging modalities
7 on the part of some physicians, concerns about self-
8 referral, direct-to-consumer marketing of imaging
9 services, repetition of imaging studies, and poor quality
10 of imaging equipment, or just in general concerns about
11 the technical quality of imaging services.

12 What I'd like to do now is just briefly
13 summarize what we said about those latter three strategies
14 for the chapter. Turning first to the matter of safety
15 standards and inspections, we heard about a study which
16 showed that failure rates on inspections of imaging
17 facilities approached 50 percent, depending upon the type
18 of practitioner operating the facility. Different kinds
19 of problems were identified, a couple of them had to do
20 first off with the age of equipment; just use of old
21 equipment, used equipment, that kind of thing. The other
22 was incorrect equipment, wrong equipment for the job. We
23 had the vivid example of dental equipment used for x-rays
24 of toes.

1 So what we have here is a strategy that is
2 essentially in two parts. We have, one, the development
3 of standards, and the second has to do with the field work
4 of actually inspecting the facilities. When we look at
5 current activities of the federal government we see a
6 couple of parallels here. The first has to do with the
7 work of the Food and Drug Administration in inspecting on
8 a regular basis some 9,000 or so outpatient imaging
9 facilities. They do so under authority of the Mammography
10 Quality Standards Act that was passed in 1992.

11 The other area where we see some similarities
12 has to do with the rather extensive program of survey and
13 certification that is administered by CMS. The standards
14 involved here go by a couple of different names, one,
15 conditions of participation, the other, conditions of
16 coverage kind of depends on the type of the service and
17 setting. But in any case, what we're talking here about
18 is a set of standards primarily for institutional
19 services, hospitals, SNFs, that kind of thing, some Part B
20 coverage having to do with renal dialysis facilities. But
21 the notable exception here is physician services that are
22 not subject to survey and certification at all with the
23 exception of the last item that's listed here which has to
24 do with clinical laboratory services. Under authority of

1 the Clinical Laboratory Improvement Amendments passed in
2 1988 CMS is doing survey and certification of clinical
3 labs, many of which are in physician offices. So that's
4 the story with respect to this first strategy, standards
5 and inspections.

6 Then we can turn to another strategy,
7 privileging, which can be defined as a policy of
8 restricting payment to certain physicians based on things
9 like specialty, qualifications or other criteria. This
10 strategy too is responding to concerns about technical
11 quality as are the safety standards, but also concerns
12 about proliferation of equipment and self-referral.

13 CMS has some experience with this kind of a
14 strategy. The obvious example here has to do with the
15 policy having to do with coverage for services provided by
16 chiropractors. There is essentially one service covered
17 here and that's manipulation of the spine. Other examples
18 have the do with a recent policy adopted with power-
19 operated vehicles, also known as scooters. Here because
20 of some concerns about fraud and abuse and rapid
21 acceleration and growth in use of these devices CMS has
22 established some criteria saying that only selected
23 physicians can order these things. This would be
24 physicians specializing in rheumatology, physical

1 medicine, orthopedic surgery, or neurology.

2 The other thing that we could do here is to link
3 the idea of privileging with limits on self-referral. As
4 you know, under the Stark laws there are restrictions on
5 self-referral. Physicians cannot referred Medicare or
6 Medicaid patients to entities which they or members of
7 their family have a financial interest. These entities
8 covered by the law include radiology services, but other
9 things too like laboratory services, physical therapy,
10 home health, and durable medical equipment.

11 The topic of self-referral admittedly is a very
12 complex one, one that we'll take on in the context of work
13 on a report concerning specialty hospitals, a report that
14 you'll hear about tomorrow. But suffice it to say for now
15 that we have a contractor working on this with some legal
16 expertise in the area. But for now let me just say that
17 one way to think about what the panelists said last month
18 in the context of self-referral is that they view their
19 privileging policies as a way to fill a gap that's not
20 addressed by Stark. That would be that if we think about
21 Stark as covering things like referral to the lab down the
22 street, the imaging center down the street, that leaves
23 then the other form of self-referral, which is referral of
24 patients to in-office equipment; the orthopedic surgeon

1 who has an MRI machine in the office. So we could view
2 the privileging strategies of private insurers as a way to
3 address that form of self-referral not addressed by Stark.

4 That then brings us to the third strategy here
5 which is coding edits. This one from our perception seems
6 to be the one that's most similar to current Medicare
7 policy. Recall that these coding edits are rules that are
8 invoked during claims processing to make decisions about
9 whether or how much to pay for billed services. Medicare
10 has a system, a mechanism in place for developing these
11 edits called the correct coding initiative, a transparent
12 process that allows for input from the physician
13 community. The result is a set of edits that are in the
14 public domain, and it turns out that private insurers
15 often use those edits. They then add to them in a couple
16 of different ways.

17 For example, they might have edits that compare
18 billed services to practice guidelines. They might also
19 make some payment adjustments when multiple services are
20 billed on a single claim. A good example of this would be
21 computed tomography services where they would pay a full
22 payment for -- imagine a patient comes in for two CT
23 services, one of the abdomen, another of the pelvis. They
24 would pay the full rate for one of the procedures, but a

1 discounted rate on the second one.

2 Medicare has a similar policy like that now for
3 surgical services, but nothing for anything other than
4 that and certainly not for imaging services.

5 So just to wrap things up here, we have heard
6 from a panel. We've heard about a number of ideas, see
7 some parallels between what private insurers are doing and
8 Medicare policy. The question now is, should we go
9 further in learning more about ways to perhaps adapt these
10 policies for the Medicare program?

11 Next steps in doing so would include things like
12 looking more closely at what private insurers are doing,
13 comparing that to Medicare and existing policy, and
14 understanding better what the feasibility is of actually
15 importing some of these strategies.

16 The other thing to learn about would be just
17 effectiveness, and what kinds of savings experience the
18 private insurers have had with these strategies, what the
19 implications are for quality and that kind of thing.

20 Jill now is going to talk about the idea of next
21 steps from a broader perspective on purchasing strategies
22 overall.

23 DR. BERNSTEIN: Looking ahead to where we go
24 from here, the chapter ends with a very brief overview of

1 some broad evaluation issues. The first have to do with
2 the current structure of the Medicare program and the
3 chapter includes a brief overview of some issues related
4 to law and regulation and to Medicare's purchasing
5 authority. The other issue look more closely at the
6 specific issues surrounding individual purchasing
7 strategies and what they might mean in fee-for-service
8 Medicare.

9 A basic question is, how would different
10 purchasing strategies affect Medicare beneficiaries? We
11 would also want to know how a purchasing strategy might
12 affect the delivery system that serves beneficiaries and
13 therefore might affect their access to care. And finally,
14 could the Medicare program administer a particular
15 strategy effectively?

16 We look forward to your comments on this and the
17 rest of the chapter.

18 MR. HACKBARTH: Questions or comments?

19 DR. NEWHOUSE: There was a suggestion made at
20 one point in this chapter on the availability of CMS
21 claims data to other carriers for purposes of profiling,
22 and since in many markets many carriers have very small
23 market shares it's not really feasible for them to
24 profile. I was wondering if we should make a

1 recommendation to the Congress that they authorize that,
2 since my understanding is that CMS is worried that that's
3 beyond their pay grade to do.

4 MR. HACKBARTH: Any reaction to that?

5 MS. MUTTI: We definitely heard that from a
6 number of people that we interviewed, that they would be
7 anxious to get that data, and we understood that CMS was
8 unclear whether they had the legal authority to do that.
9 There was privacy issues raised, concern about people
10 being able to identify beneficiaries. But the advocates
11 of having access to that information pointed out that they
12 thought that it could be done in a way so that
13 beneficiaries' identification was suppressed. But I think
14 some people are concerned about the physician
15 identification being so available.

16 MR. FEEZOR: That was mentioned at the top of
17 page 10, that gets into what she just said and would be a
18 place if we want to insert that.

19 MR. HACKBARTH: Other questions, comments?

20 MR. FEEZOR: Mine dealt more with -- Kevin,
21 first off thank you for your view on the imaging. We
22 somehow need to really drive home just the growth of that
23 even more than perhaps we do.

24 My comment that struck me most and I felt we

1 were maybe shortchanging our readers a bit was in the
2 reference to the health resource accounts. We talk about
3 conceptually what they're used for, but we don't mention
4 the fact in terms of the pretax, post-tax. We don't get
5 into any discussion on that, and I think that would be
6 very helpful to have that spelled out a little bit more.
7 And then particularly the ability to do any rollover on
8 that, and whether or not we are talking about active
9 versus passive income, since the latter is more applicable
10 to retirees.

11 Then one other observation, and if didn't come
12 out in your analysis or discussion with other third-party
13 payers, but all on the centers of emphasis, centers of
14 excellence I noticed that geographic distance was not
15 listed as an issue that had to be dealt with. I know in a
16 couple of programs that we looked at when I was on the
17 payers' side, that was a very real thing, the ability to
18 move large amounts of that specialty to areas that were
19 more than 70 or 100 miles away frequently; was a big
20 issue. One of the ways we dealt with that was basically
21 coming up with an accompaniment benefit where you actually
22 pay for families hotel for a brief period a time. If that
23 was not found or any of the folks that you interviewed
24 that was not an issue, then not. But otherwise, it seems

1 to me that's one of the things, real barriers to using the
2 centers of excellence, centers of emphasis.

3 DR. WOLTER: I'd just underscore, think the
4 self-referral issue is a very important issue and we do
5 have areas that are well-defined where it's clearly
6 identified as a conflict of interest, and then we have
7 other areas where it remains not very well-defined. It is
8 complicated but I think it's an important issue which is
9 driving lots of investment in various parts of the health
10 care sector today. So I'll be quite interested to see
11 what your contractor comes up with and how we might
12 approach defining that even more.

13 I think the other thing I would just mention in
14 terms of approaches to the rapidly growing cost in imaging
15 -- and I certainly don't have my hospital or physician or
16 rural hat on right now -- but it is one of the highest
17 margin activities in health care. I think that doesn't
18 mean that people are necessarily doing a lot of
19 inappropriate things. There's lots of reasons why imaging
20 has grown and people need the service, but it is very high
21 margin, so I think payment rates are certainly part of the
22 issue.

23 DR. MILLER: Kevin said this but I'd just like
24 to draw it out for people, and you've touched on it again

1 so I just want to say it. I think there's one path that
2 we will pursue and plan to pursue where we're going to
3 look at self-referral and talk about how it got where it
4 is and how the rules apply. This gets particularly
5 complicated because we're talking about in-office types of
6 activities where self-referral gets incredibly
7 complicated.

8 The point I just want people to track on is,
9 what Kevin was reminding us that the panel said is, they
10 go at that issue differently. So they may, instead of
11 going through a self-referral exercise, go through a
12 privileging exercise. I realize for Medicare that's a
13 very complicated policy area. But I just wanted to draw
14 that point for you, that for the private sector, some of
15 these people go at that issue a little bit differently,
16 which is not to say that we won't be taking that issue on.
17 I just wanted to make sure that that point caught people's
18 attention.

19 MR. HACKBARTH: Others?

20 Like Allen Feezor, I thought that maybe we could
21 elaborate a little bit more on why we elected to include
22 imaging as an example within this. I think we just cross-
23 reference some previous Medicare work, but I think it
24 might be helpful just to elaborate on the growth and the

1 like without prejudging in any way what policy measures,
2 if any, ought to be taken.

3 But I do feel like this is a good area for us to
4 explore next year and do intend to come back. Maybe we'll
5 decide it is a fruitful area; maybe not. I don't know.
6 But I think there are a number of reasons, not least of
7 which is what we heard from the panel last time, that we
8 ought to take a close look at this.

9 DR. NELSON: Somewhere see if you can insert a
10 sentence about the role that direct-to-consumer
11 advertising of these capabilities is playing, because I
12 don't know how it is in other markets but there's sure a
13 lot of stuff on the air about open CTs, and it's not
14 unheard of for patients now to go into their physicians
15 and say, my knee hurts, I want a CAT scan on it. The
16 demand management piece of this is something that at least
17 needs to be acknowledged.

18 DR. STOWERS: I just read an article again the
19 other day about the increase in x-ray use and that kind of
20 thing is connected to the PLI crisis in the country, and
21 there's a lot more -- we've always had trouble measuring
22 defensive medicine and all of that, but there are some
23 things coming out about that particular crisis going
24 across the country now, increasing the amount of images

1 and ordering them quickly than we did five or six years
2 ago when that person asked for the knee or the abdominal
3 pain or whatever. We're a lot quicker to get the higher-
4 priced scanning and that kind of thing than we were a few
5 years ago. That's definitely true in our emergency rooms.

6 MR. HACKBARTH: Anything else?

7 Okay, thank you.

8 Next is another descriptive piece on the
9 characteristics of independent diagnostic testing
10 facilities and ambulatory surgical centers.

11 MR. WINTER: Thank you. As Glenn said, I'll be
12 talking about two types of facilities that focus on
13 different kinds of outpatient services. One you've heard
14 about before and that's ASCs. The other type we'll be
15 discussing for the first time and that's independent
16 diagnostic testing facilities or IDTFs. We'll be looking
17 at IDTFs because they're a growing provider of imaging
18 services and are an example of how CMS has attempted to
19 regulate the provision of these services.

20 So here's the overview of the presentation.
21 First I'll explain what IDTFs are and what services they
22 provide. We'll look at the growth of spending for IDTF
23 services, raise some policy questions and think about next
24 steps. Then we'll turn our attention to a couple of ASC

1 related issues. We'll continue our analysis of the extent
2 to which ASCs specialize in certain services, which will
3 be useful as we think about the development of a new ASC
4 payment system. Finally, we'll discuss the
5 characteristics of markets in which ASCs are located.

6 A facility that provides diagnostic service that
7 is independent of a hospital and physician office must
8 enroll with Medicare as an IDTF. Later on I'll explain
9 the details of this definition. Medicare spent about \$740
10 million for IDTF services in 2002. This includes both
11 program spending and beneficiary cost-sharing. Imaging
12 procedures accounted for about 85 percent of all IDTF
13 spending, or \$630 million. The remainder was primarily
14 for tests, such as electrocardiograms and cardiac stress
15 tests.

16 To put this in perspective, total Medicare
17 spending for imaging services paid under the physician fee
18 schedule was about \$8 billion in 2002. So IDTFs accounted
19 for about 8 percent of imaging spending.

20 This chart shows the distribution of IDTF
21 spending by type of service. MRI was the largest category
22 at 41 percent, followed by tests, cardiac catheterization
23 and related imaging, other echography, which is
24 ultrasound, and CT, or computed tomography. IDTFs are

1 paid under the physician fee schedule at the same rates as
2 physician offices. Under the fee schedule, Medicare makes
3 separate payments for the technical component and
4 professional component of a test unless both components
5 are furnished by the same provider. The technical
6 component covers the cost of the equipment and non-
7 physician staff while the professional component covers
8 the physician work involved.

9 As you've heard before in other contexts,
10 spending on imaging services paid under the physician fee
11 schedule has been growing rapidly. It increased by 27
12 percent between 2000 and 2002. Spending for the portion
13 of these services provided in IDTFs grew more than three
14 times as fast during this period. The fastest growth in
15 IDTF services occurred among cardiac catheterization and
16 related imaging, CT, and nuclear medicine. We identified
17 2,400 IDTF entities in 2002 using 2002 Medicare claims.
18 This represented a 35 percent increase from 2000. Each
19 entity may have more than one location which may be fixed
20 or mobile, such as a trailer. We identified 3,600
21 separate locations in 2002 which is an average of almost
22 1.5 per entity.

23 We also looked at what kind of services high-
24 volume IDTFs provided. We wanted to learn what share of

1 these facilities specialize in a single type of procedure.
2 That is, they derived at least 90 percent of their
3 Medicare revenue from a single procedure category. We
4 found that only 30 percent specialize in one category of
5 services, which was mostly MRI or tests.

6 We also plan to look at the geographic
7 distribution of IDTFs and the characteristics of markets
8 in which they're located.

9 The rapid growth of IDTF spending raises the
10 following questions. Why did CMS create this category and
11 how does CMS distinguish IDTFs from physician offices?
12 What rules does CMS apply to IDTFs, and how are they
13 monitored? Medicare created the IDTF category for
14 freestanding diagnostic centers in 1998. Previously these
15 entities were largely unregulated by CMS or the states.
16 The Office of Inspector General and CMS had found evidence
17 of fraudulent behavior and inappropriate use of services
18 by freestanding centers. There were also safety and
19 quality concerns. Thus, CMS developed the IDTF category
20 and its rules to address these problems.

21 To elaborate on the definition I gave you
22 earlier, a diagnostic center is considered to be
23 independent of a hospital and physician office and thus
24 required to enroll as an IDTF if it is not a physician

1 practice that is owned by one or more physicians or a
2 hospital, if it primarily bills for diagnostic tests
3 rather than other physician services such as evaluation
4 and management, and if it provides diagnostic tests
5 primarily to patients whose conditions are not treated by
6 physicians in the practice. In other words, it's sole
7 purpose is to provide diagnostic tests, services to
8 patients who conditions are treated elsewhere.

9 A radiology practice is different in nature than
10 other physician practices because it primarily performs
11 and interprets radiological tests but does not treat
12 patients' underlying conditions. Thus, CMS applies
13 different criteria when deciding whether a radiology
14 practice is a physician office. The radiology practice is
15 exempt from enrolling as an IDTF if the practice is owned
16 by a radiologist or hospital, the radiologists provide
17 test interpretations at the location where the diagnostic
18 tests are performed, and the practice primarily provides
19 professional services of the radiologist.

20 Some diagnostic services are exempt from the
21 IDTF rules. These are mammography, which is regulated by
22 the FDA, certain tests furnished by audiologists, physical
23 therapists, and clinical psychologists which do not
24 require physician supervision, and clinical laboratory

1 tests which are regulated by the Clinical Laboratory
2 Improvement Amendments.

3 IDTFs are subject to the following rules which
4 do not apply to physician offices that furnish diagnostic
5 tests. They're required to go through an enrollment
6 process with the carrier in their your area. They must
7 have at least one supervising physician who oversees the
8 quality of the testing, the operation and calibration of
9 the equipment, and the qualifications of the non-physician
10 staff. The non-physician staff must be licensed by the
11 state or certified by a national credentialing body. All
12 procedures performed by an IDTF must be ordered in writing
13 by the beneficiary's treating physician. And finally, the
14 list of procedures they wish to provide must be approved
15 by their carriers.

16 Before enrolling IDTFs in Medicare, the carriers
17 must verify through document review and a site visit that
18 the IDTF actually exists, that it meets the requirements
19 that we mentioned on the previous slide, that the
20 equipment it uses is properly maintained and calibrated.
21 However, CMS does not specify the standards carriers
22 should use in evaluating the equipment.

23 IDTFs are not subject to ongoing monitoring such
24 as repeat site visits except under certain circumstances.

1 The OIG plans to review whether services provided by IDTFs
2 are medically necessary, there is adequate physician
3 supervision, and non-physician are properly licensed or
4 certified. The IG's concern underscores why we're
5 interested in how these facilities are monitored.

6 So where do we go next, both with regards to
7 IDTFs and on the broader topic of imaging services?
8 Presumably our overarching goal is to control growth in
9 the cost and use of these services while at the same time
10 ensuring access to appropriate high-quality care. This
11 could be a difficult balance to achieve between these two
12 objectives.

13 So what tools can we use to accomplish this
14 goal? These could include some of the methods that CMS
15 uses to regulate IDTFs as well as some of the private
16 purchasing strategies we heard about earlier. We could
17 also think about incorporating some of the methods that
18 the federal government uses to regulate mammography and
19 laboratory services.

20 Then finally, in what settings should we apply
21 these tools? Should they be limited to freestanding
22 facilities like IDTFs, or also apply to physician offices?
23 At the end of the presentation we'd like to get your
24 feedback on these questions.

1 Now I'll move on to the ASC topics. For our
2 March report we tried to characterize ASCs by what
3 services they provide. We used 2002 claims data to
4 estimate the proportion of single specialty and
5 multispecialty ASCs certified by Medicare. This is an
6 important issue changes to the ASC payment system may
7 affect single specialty and multispecialty facilities
8 differently. For example, a large reduction in rates for
9 eye procedures could have a bigger impact on an
10 ophthalmology ASC than an ASC that performs a variety of
11 procedures. It's also relevant because facilities that
12 specialize in one type of procedure may be more efficient
13 and thus have a different cost structure than a
14 multispecialty facility.

15 Since the March report we started to track
16 changes in the mix of ASCs over time and we'd like to
17 share our results with you. I just briefly want to review
18 our methodology. We selected high-volume ASCs, those that
19 submitted at least 1,000 claims, so that we'd have an
20 adequate sample size to look at, and we looked at their
21 share of Medicare revenue related to each physician
22 specialty. We define a single specialty ASC as one with
23 at least 90 percent of revenue related to one physician
24 specialty. The others we classified as multispecialty.

1 Using this threshold we found that about half of
2 ASCs are single specialty, which is consistent with what
3 an industry survey has found. In the future we may change
4 our definition to one based on the type of procedures that
5 ASC's provide rather than the specialty of the physician
6 providing them. This would be more consistent with how we
7 plan to categorize specialty hospitals as you'll hear
8 about tomorrow.

9 So using 2000 data we identified 750 high-volume
10 Medicare-certified ASCs, and we found that 56 percent were
11 single specialty, mostly ophthalmology or
12 gastroenterology. By 2002 the number of high-volume ASCs
13 increased to over 1,200. While the number of single
14 specialty ASCs increased, they declined as a share of all
15 high-volume ASCs to 48 percent. This decline was driven
16 by a steep drop in the share of ophthalmology ASCs from 37
17 to 27 percent. During the same period Medicare payments
18 to ASCs for eye procedures did not increase as fast as
19 payments for all procedures.

20 In previous MedPAC reports we've noted that ASCs
21 tend to be concentrated in specific states. We've now
22 started to drill down on what variables affect ASC
23 location in specific markets. This should help us better
24 understand the factors influencing ASC growth.

1 The first question is what geographic unit best
2 approximates an ASC market area, a county, metropolitan
3 statistical area or MSA, or a market defined by patterns
4 of hospital use? We currently have a study underway that
5 uses data on where an ASC's patients live to help define
6 an ASC market area. In the meantime, we have used MSA and
7 counties as proxies for ASC markets and looked at the
8 characteristics of areas with different levels of ASC
9 concentration. Our results from MSA and county analyses
10 were similar so I'll only be presenting the MSA results.

11 We divided MSAs into quartiles based on the
12 number of ASCs per 1,000 population in each area. We
13 compared MSAs in the lowest quartile of ASC concentration
14 to MSAs in the highest quartile. Areas with the most ASCs
15 tended to have smaller average population size, faster
16 population growth, lower managed-care penetration, higher
17 poverty rate, and more hospital beds and surgeons. There
18 was almost no difference between high and low ASC areas in
19 terms of median income, the share of the population over
20 65, use of all Medicare services, and beneficiary risk
21 scores.

22 Some of these results make sense. For example,
23 it's not surprising that ASCs tend to be located in
24 markets with faster population growth, which probably

1 indicates a growing market for health care services, with
2 more surgeons who can do the surgical procedures, and
3 lower managed-care penetration which might indicate looser
4 provider networks.

5 However, some of these results are puzzling.
6 For example, we would have expected ASCs to choose markets
7 with higher median incomes and greater Medicare service
8 use, which might indicate stronger demand for surgical
9 services.

10 We also looked at the relationship between ASC
11 location and the presence of state certificate of need
12 laws that regulate ASC development. In 2002, 61 percent
13 of ASCs were located in the 24 states without these
14 requirements. These states accounted for 57 percent of
15 the U.S. population and 56 percent of beneficiaries, so it
16 doesn't appear that CON laws by themselves play a major
17 role.

18 For our next steps we plan to use multivariate
19 analyses to isolate the impact of variable while
20 controlling for other factors. We also plan to the look
21 at whether there are common factors that influence the
22 location of ASCs and other specialized entities such as
23 IDTFs and specialty hospitals.

24 Finally, we intend to examine whether markets

1 with high ASC concentration process are associated with
2 greater overall use of surgical services. This study is
3 part of our specialty hospital workplan which Carol and
4 Julian will be discussing tomorrow.

5 This concludes my presentation and I look
6 forward to your feedback and discussion.

7 DR. STOWERS: I just want to make a comment. If
8 you level out for quality and the physician knows the
9 facility and knows that it's going to provide essentially
10 the same service as what is provided in the hospital, I
11 think one thing that explains this growth and that sort of
12 thing that I didn't see discussed in here was the fact
13 that usually the upfront charge to the patients in these
14 facilities is dramatically less than what it is in the
15 hospital. So you may want to get that average charge
16 data.

17 But even more than that, from the patient's
18 perspective, the copay or amount that -- because it's Part
19 B, or if the patient is a private pay patient or with some
20 insurance is dramatically less. I referred to CAT scan
21 last month that was \$2,000 in the hospital, cost a total
22 of \$900 in one of these facilities. The patient's
23 responsibility dropped from \$1,000 to \$1,100 down to
24 \$390. So I just think that part of the growth I know out

1 in the rural community is just the fact that a lot of it
2 is patient driven. They're convenient. They can get it
3 at a more economical cost. As we get a broader part of
4 our population that doesn't have that employee insurance
5 and all the other things that they've had in the past this
6 is becoming more and more attractive as an economical
7 place to get their health care done.

8 DR. ROWE: I think while the name says
9 diagnostic, some of the procedures that are done in the
10 diagnostic vendors are actually therapeutic and not just
11 diagnostic, such as getting coronary angiogram or an
12 angioplasty. Is that the case?

13 MR. WINTER: I don't see any claims for
14 angioplasties or stents. When they do cardiac
15 catheterization it's just the angiogram. They bill for
16 two things. They bill for placement of the catheter and
17 the related imaging is just an angiogram. That's what's
18 showing up in the claims.

19 DR. REISCHAUER: It might be interesting to do a
20 case study of colonoscopy. Here's something that is newly
21 covered, number one. Certainly is pretty far down on the
22 list of the things that people want to have done, is
23 pretty far up on the list of things that people should
24 have done and aren't having done, are done in outpatient

1 settings and in ASCs, and probably, although I don't know,
2 much more efficiently done in a non-hospital setting, I
3 mean from the standpoint of the individual. It's less of
4 a hurdle and all that. To look at both the amount of this
5 that's going on in these kinds of settings versus
6 hospitals over a period of time and see if we can ferret
7 out something. I don't think you can argue that there's a
8 lot of inappropriate colonoscopy going on. So we just get
9 rid of that issue and try and look at the pure what's left
10 in the market.

11 MR. HACKBARTH: So this would be a way of
12 testing whether these new types of facilities are
13 increasing access, and attractive?

14 DR. REISCHAUER: More attractive to individuals,
15 things like that.

16 MR. WINTER: The last couple of times we've
17 looked at that, at the trends in site of care for
18 different kinds of services, colonoscopy is increasing in
19 ASC essays relative to outpatient department and physician
20 office, but we haven't updated that in about a year and-a-
21 half or two years, so we could look at that again.

22 DR. REISCHAUER: We can look across metropolitan
23 areas and see if an infusion of ASCs creates greater
24 utilization.

1 DR. NELSON: A comment and a question. The
2 comment, I understand why these are commingled, these two
3 categories of facilities for the purposes of your
4 research. But if this were to appear in the form of
5 chapters the audiences for it would almost certainly say
6 that ambulatory surgical centers are vastly different from
7 than independent testing facilities. One provides
8 therapeutic services, the other diagnostic and so forth.
9 So after the work is done, if it sees the light of day in
10 publication I would hope that they would be separated in
11 some fashion.

12 DR. MILLER: This was completely a convenience
13 of organizing some information for the purposes of
14 presentation here. We had a couple things that were
15 responding to questions, couple of things were getting off
16 the ground. Ariel was doing both of them so we just
17 packaged it for -- these things are headed to different
18 homes in the long run.

19 DR. NELSON: I assumed that that was the case
20 but I wanted reassurance and thank you for that.

21 The second is that, I wonder the degree to which
22 these facilities has grown is a product of managed-care
23 contracts? Where, for example, my managed-care entity
24 when I or a member of my family needs an imaging service

1 we go to one of these and it's because that's whom they
2 have a contract with, rather than selecting hospital
3 facilities to contract with.

4 That may not be as much a factor in
5 Medicare+Choice but their existence and growth may be a
6 product of managed-care penetration. I don't know and I
7 don't know that it's worth doing a lot of digging to find
8 out, but if there's an easy way to correlate those two it
9 might be interesting.

10 MR. WINTER: As we did with the characteristics
11 of ASC markets we're also going to look at what are the
12 characteristics of markets with lots of IDTFs and few
13 IDTFs, and one of those factors we'll look at is managed-
14 care penetration. So we can try to get at that at least
15 broadly speaking.

16 MR. MULLER: My question is essentially the
17 same. If they have these costs and convenience
18 attributes, how are private payers incentivizing the use
19 of them, the ASCs, the diagnostic facilities and so forth?
20 That in a sense is a test case because they have clear
21 financial incentives to do so, if in fact this steers
22 patients towards a lower-cost or a higher benefit type of
23 setting. So if there's any evidence that we have that
24 there's clear incentives in that market to drive people in

1 this direction versus the hospital outpatient setting and
2 so forth. That would be useful to see as an example of
3 the questions we're asking.

4 MR. WINTER: We'll look into that.

5 MS. ROSENBLATT: I don't know how you get
6 statistically at this issue but Ray and I were just having
7 a side conversation here. There is something different
8 about these ambulatory surgical centers in terms of the
9 ambiance versus a hospital. I really think that -- I'll
10 count myself in. Depending on what I'm having done, I'd
11 rather go to an ambulatory surgical center just because
12 there's a different environment than there is in a
13 hospital. I have a feeling I'm not unique in that.

14 MR. WINTER: We've recently some site visits to
15 ASCs in the D.C. area, two endoscopy centers and a
16 multispecialty facility and they're very nice. My son
17 recently had surgery at an ASC in Montgomery County and it
18 was also a very positive experience, so I can see the
19 attraction. Maybe not for him.

20 MS. ROSENBLATT: I've been to one in Beverly
21 Hills where it looked more like a hospital spa.

22 DR. ROWE: I don't know much about Beverly Hills
23 I'm just a guy from Hartford, Connecticut, but I would say
24 a couple -- while ambulatory surgery centers are

1 attractive and many of them that's because they're new
2 because of this growth. They're different in a number of
3 ways. Often the cost is lower because the workforce is
4 not an organized bargaining unit whereas in hospitals they
5 ordinarily are. That's one of the other differences, not
6 that that should guide our policy one way or the other.

7 Secondly, there's very little training that goes
8 on in these facilities. There are very few residents in
9 these facilities. Usually when the procedures occur in
10 the hospital outpatient department, the residents are
11 rotating there, et cetera. These are often in remote
12 locations.

13 I think, thirdly, the patient population is
14 different. Alice is a good example of a healthy, young
15 woman who can go to an ambulatory surgery center. A
16 frail, older Medicare beneficiary with multiple
17 comorbidities is not as well managed always in that kind
18 of an institution, particularly if the procedure carries
19 greater risk of an adverse event because of the condition
20 of the patient.

21 So before we get irrationally exuberant about
22 these beautiful new spas and/or ASC, I think they play a
23 role. It's okay that there's not much training as long as
24 there's enough training, colonoscopies or whatever it is,

1 for the residents to get the training that they need to be
2 able to take care of Medicare beneficiaries. They don't
3 need to be there for every case. So they do play an
4 important role, but it's part of the picture and has to be
5 seen as part of the picture.

6 MR. WINTER: Just to make a note here to Jack,
7 our research on patient mix differences between ASCs and
8 outpatient departments supports what you're saying about
9 the frailer and sicker patients go to outpatient
10 departments.

11 MS. ROSENBLATT: If I could just make one
12 statement in my defense here before I get connected with
13 Beverly Hills. This is probably another issue that we
14 need to be careful about. I was ill when I went to that
15 Beverly Hills ambulatory surgical center. It was done
16 under doctor's advice and if I had it to do over again I
17 would have done the procedure in a hospital, not at the
18 ambulatory surgical center. So I really do think patients
19 like myself are being sent to the wrong venue at times.

20 MR. MULLER: Along those lines, some of the
21 states that have more restrictions on things -- there's a
22 reason that they do ophthalmology and those more simple
23 procedures, is literally you have one case that goes sour
24 in one of these settings because somebody went there and

1 there wasn't the appropriate backup, that usually then
2 leads to some kind of regulatory fever to stop their
3 explosion. So I know you don't have as much -- it's kind
4 of hard to -- your variable is more CON and non-CON, and
5 I'm not sure there's any good way of sorting out a
6 variable there that has a little bit more power than just
7 the on-off switch of whether you have CON or not. But
8 sometimes you do see that, that the regulatory climate
9 does change when some more complex case is done and then
10 something happens.

11 MR. DeBUSK: From a device standpoint, the roles
12 that ambulatory surgery centers play today will be
13 completely different in the future because of the research
14 and development and the dollars that are being spent today
15 on devices and what have you is around the 23-hour stay in
16 the surgery center. A great deal is going on there with
17 that. They're even doing hips at Duke University on an
18 outpatient basis now. So that is going to change.

19 MR. HACKBARTH: Anybody else?

20 Okay, thank you very much.

21 Next is hospice care.

22 MS. BOCCUTI: Good afternoon. In this
23 presentation I'm going to review a few of the points that
24 Sarah raised in the last meeting and note some growth

1 trends in the hospice provider community. Then I'm going
2 to discuss some payment refinements that have been
3 proposed, and finally, I'd like to leave plenty of time
4 for the Commission to discuss these issues and comment on
5 the draft chapter.

6 In brief, hospice is a set of palliative care
7 benefits for terminally ill beneficiaries with a prognosis
8 of six months or less to live if their illness runs an
9 expected course. The services covered within the hospice
10 benefit includes skilled nursing, therapy, home aide,
11 homemaking, some physician services, nutrition counseling,
12 medical social services, bereavement and pastoral care,
13 respite care, prescription drugs, DME, and medical
14 supplies. These services may only be provided for
15 palliative indications because beneficiaries who elect
16 hospice care must forego curative treatment for their
17 terminal illness. However, Medicare continues to cover
18 curative care for conditions unrelated to the terminal
19 illness.

20 Once a beneficiary enrolls in hospice care, the
21 agency caring for the patient is paid a fixed amount daily
22 for that patient regardless of how often an agency staff
23 person visits the patient. 95 percent of payments are
24 made at the routine health care level. The remaining 5

1 percent of payments are higher and are made when patients
2 are receiving inpatient care, continuous health care, or
3 respite care.

4 There are two kinds of payment caps. Although
5 most agencies do not receive them, some agencies have
6 publicly noted in their investor reports that they've
7 exceeded Medicare's total annual payment cap, which in
8 2003 was about \$18,700 per served beneficiary. The
9 hospice payment system has no outlier payments. It also
10 has no case-mix adjustment. Under current law daily
11 payments are automatically updated annually based on the
12 hospital marketbasket.

13 Growth in the use of the hospice benefit has
14 been substantial. Among fee-for-service beneficiaries who
15 died hospice has grown from about 16 percent in 1998 to 25
16 percent in 2002. The average number of days in hospice,
17 which is generally the number of days beneficiaries are in
18 hospice before they die, has increased to 55 days. The
19 median, however, has remained constant due to the steady
20 share of beneficiaries who are in hospice less than a
21 week.

22 Recalling Sarah's presentation last month,
23 growth in hospice use has been greatest among several
24 types of beneficiaries, those that are the oldest, those

1 with non-cancer diagnoses, and those who reside in nursing
2 facilities. It seems clear that in many cases we're
3 talking about the same patients. That is, beneficiaries
4 who reside in nursing homes are more likely to be older
5 and have terminal illnesses other than cancer, and with
6 all these factors have a longer length of stay.

7 Finally, with more people enrolling in hospice
8 and having longer hospice stays on average Medicare
9 spending on hospice has increased substantially. CMS's
10 Office of the Actuary estimates Medicare outlays to have
11 doubled between 2000 and 2003.

12 So the growth in hospice can be due to several
13 factors. First, there appears to be an increase in the
14 demand for hospice care. It's a form of care appropriate
15 for the dying population and beneficiaries and physicians
16 are likely accepting and appreciating it more. Indeed it
17 was in past years, and likely still is, underused by
18 Medicare beneficiaries with terminal illness. CMS has
19 also made efforts through publications to physicians to
20 promote the use of hospice care by appropriate
21 beneficiaries.

22 Second, new provider entry into the market,
23 which I'll get to in a minute, indicates that the
24 financial environment for providing hospice care is likely

1 very favorable.

2 This table on this slide shows the types of
3 hospice providers in the industry. As you can see, not-
4 for-profit programs remain the largest share of the
5 industry but their share has dropped slightly each year.
6 Moving down to the hospice types, we see four types:
7 freestanding, home health, hospital and SNF-based. I want
8 to make it clear here that the term freestanding is
9 sometimes a bit of a misnomer. It does not necessarily
10 indicate that it's a brick and mortar freestanding
11 building. But rather it means that the hospice is not
12 based on another type of provider. Also for clarity,
13 hospital-based facilities do not necessarily provide care
14 in a hospital. They're simply owned by a hospital and may
15 provide services in patient homes. Freestanding
16 facilities compose the largest share of hospice agencies
17 as most for-profit agencies are freestanding hospices.

18 Just as the number of beneficiaries using
19 hospice has increased, so has the number of hospices. As
20 you can see in this slide, the number of for-profit
21 facilities has grown 25 percent, significantly more than
22 facilities with other types of ownership. Freestanding
23 facilities have also shown considerable growth. CMS
24 collects this kind of data on an ongoing basis and they

1 reported to us that growth in 2004 is continuing along
2 these same trends. CMS stated to us that provider growth
3 is primarily due to new facilities entering the market.

4 However, some investor reports and articles in
5 the business trade press have noted acquisition of not-
6 for-profits by for-profits. Keep in mind that because
7 hospice benefits are usually provided in patients' homes,
8 the hospice industry can also grow through increases in
9 its capacity. We have found that the number of high-
10 volume hospice agencies is increasing while the number of
11 low-volume hospices is declining.

12 This final slide lists an array of policy
13 options and considerations that have been proposed by
14 various scholars and organizations including MedPAC in the
15 past. First here we have case mix. Case-mix adjustments
16 attempt a refine provider payments to reflect the costs
17 for furnishing services to a given impatient. In doing
18 so, case-mix adjustments can improve access to care for
19 patients with high cost care needs. Because the hospice
20 payment system does not have a case-mix adjustment,
21 hospices have financial incentives to enroll patients
22 whose costs are expected to be low and deny enrollment to
23 those with high expected care costs.

24 An article that was published in last week's

1 Journal of the American Geriatric Society revealed that
2 some hospices deny admission based on indicators that they
3 may have high service costs. Specifically, 63 out of 100
4 California hospices surveyed in this study denied
5 admission based on at least one reason. Reasons for
6 denying patient admissions included their receiving total
7 parental nutrition, or receiving tube feedings, or
8 radiotherapy, or chemotherapy, or transfusions, or lack of
9 a caregiver in the home. This study found that the larger
10 the hospice, the less likely they were to deny admission
11 based on these kinds of criteria.

12 Hospice representatives also told us that
13 agencies which do not feel that they have the resources to
14 care for a patient do sometimes deny enrollment. Indeed,
15 some expensive services such as chemotherapy were not
16 factored into hospice cost estimations when the benefit
17 was first established because they were not use in a
18 palliative way. Costs for the hospice benefit have not
19 been recalibrated to reflect any changes in hospice care
20 practice patterns.

21 Next we have length of stay. Payment
22 adjustments related to length of stay have also been
23 suggested. Agencies with shorter lengths of stay have
24 higher average daily costs because the initial and the

1 first day are most costly. Some have suggested special
2 payments for the first and last day of care. This could
3 potentially be paired with payment adjustments from long
4 hospice stays.

5 MedPAC analysis has found that patients in for-
6 profit facilities have, on average, longer lengths of stay
7 than those in not-for-profit facilities.

8 Next on the list, rural adjustment. Another
9 article published last week confirms other studies which
10 find that urban areas have higher rates of hospice use
11 than rural areas. Rural hospices also have lower volume
12 on average than urban hospices. This low volume may raise
13 hospices' cost per case and some have suggested that
14 Medicare payments should account for these differences.

15 Type of residence. Some observers have noted
16 that hospice care for patients in nursing homes may be
17 less costly than for patients who live at home. The
18 industry has noted, for example, that a hospice can save
19 on transportation cost when serving several patients
20 within the same nursing home.

21 For dually eligible patients, hospice agencies
22 receive payments from both Medicaid and Medicare. The
23 hospice then contracts with the nursing facility to
24 provide the room and board. Further research on service

1 costs and total payments for hospice patients in nursing
2 facilities may inform payment refinement for this
3 population.

4 Outlier payments. Outlier payments have been
5 suggested to cover the cost of patients with unusually
6 high service costs. Along the same lines as case-mix
7 issue, outlier payments could assist with access to care
8 for patients on expensive therapies such as palliative
9 chemotherapy. Hospices are paid on a per-diem basis but
10 there are no visit number requirements as long as the
11 hospice follows the patient's plan of care. It might be
12 useful for Medicare to collect more data on the number
13 content of visits per patient as it does with home health
14 delivery. This information would address provider
15 accountability concerns and also help Medicare understand
16 the cost of providing hospice care.

17 And then to quality. Another area which the
18 Commission may want to explore is quality improvement and
19 reporting. Updating Medicare's conditions of
20 participation to include quality measurement and quality
21 improvement activities could be helpful. Most agencies
22 seek accreditation and in doing so meet quality
23 improvement requirements. As in other provider settings,
24 the results of quality measurement could be reported

1 publicly through a Medicare initiative. Some quality
2 measures that some hospice providers are using include
3 whether the patient was comfortable or had effective pain
4 management, and whether the patient's choice of place of
5 death were followed.

6 Under eligibility, some experts have noted that
7 the six-month prognosis requirement can be a barrier to
8 accessing appropriate hospice care. That is, people who
9 wish to give up all curative care for their illness are
10 unable to enter hospice if their physician feels unable to
11 predict their death accurately. Some have suggested that
12 hospice eligibility take acuity levels into account and
13 diagnoses as well so that people with terminal illnesses
14 that have less predictable diagnoses could receive the
15 advantage of hospice care before it's too late to benefit
16 fully.

17 Finally, managed care. Last month, Sarah
18 discussed the payment issues surrounding hospice care for
19 beneficiaries in managed care. In review, beneficiaries
20 who elect hospice care must receive their palliative care
21 from a hospice agency rather than from their managed care
22 plan. Plans receive a reduced monthly payment for hospice
23 patients but are no longer at risk for all their Medicare-
24 covered benefits. This payment circumstance deters plans

1 from developing and providing palliative care and
2 encourages a disruption in the patient's care. Some
3 managed care plans have begun developing innovative end-
4 of-life care programs but Medicare's payment policy does
5 not support the use of such programs. This payment
6 structure has also been found to increase Medicare costs
7 and add a high level of administrative complexity to plan
8 payments.

9 That concludes my presentation. I would be
10 happy to answer any questions.

11 DR. WAKEFIELD: You mentioned earlier in your
12 comments that your data show that the number of low-volume
13 hospices is declining. Do you have a sense of where those
14 low-volume hospices are in terms of geographic
15 distribution? So in other words, are they in places where
16 you already have maybe one or two or three other
17 alternatives available in a large urban area with a higher
18 volume of hospice services, or do you have a sense that
19 some of those or a lot of them might be low-volume
20 hospices that exist in rural areas, so that we might be
21 losing access to that set of services more broadly to --
22 albeit sparse, but to populations nevertheless?

23 I was interested in your comment about the fixed
24 overhead low volume issue. You cited some article that

1 have been published recently about that. Obviously we've
2 looked at those relationships before in terms of making
3 recommendations about refining payment policies to better
4 align them, given those circumstances and the hospital
5 care. So I'm interested in that point as well. But for
6 starters, any descriptive info on the geographic
7 distribution.

8 MS. BOCCUTI: I wish I could, and I'll try and
9 look for it in other places. The place where I got the
10 information on declining enrollment low-volume and
11 increasing enrollment in high-volume hospices, or the
12 number of hospices. It's not enrollment -- is from the
13 Federal Register listing. While it's broken down urban,
14 rural, it's not cross-tabbed that way so I can't figure
15 that out. But I'll look in other areas. I think that the
16 article that I brought up doesn't look across time, but
17 I'll look at that again to see whether there's a decline.

18 But I bet that if I look a little harder I could
19 come up with some of that or talk a little bit further
20 with CMS, because they have the data and we have to figure
21 out what to ask for and how to get it. So I can look into
22 that. Did that answer your second question as well?

23 DR. WAKEFIELD: It did.

24 MS. BOCCUTI: It's not a situation where I can

1 say that it's impossible to get.

2 DR. WAKEFIELD: Even on the issue of low volume,
3 you may not be able to go there either.

4 DR. ROWE: This was very interesting and I think
5 we're making real progress. I have a couple points, some
6 of which I've said before but just to reiterate.

7 First of all, I think the data and the
8 information on length to stay deserves a little more
9 analysis. You say that the length of stay went up to 55
10 days in 2002. The table 6.3 shows it at 52 days.

11 MS. BOCCUTI: It should be 55.

12 DR. ROWE: But even if it is up to 55 and you
13 say the median is constant, the median is actually
14 declining from 18 to 17 to 16, and the 25th quartiles is
15 about the same. So really the point is here that there
16 are an increasing number of very long stay, and that's
17 what's going on. The 25th quartile is about the same. So
18 I think it's worth just giving people a little bit more
19 information about that so they don't have to connect all
20 the dots themselves, because they headline otherwise is
21 going to be, average length of stay increasing, and it's
22 artificial. There are a small number of people who have
23 very long stays, and that's a good thing I think. But
24 it's just a little more information.

1 The second thing is, I don't believe we should
2 have a cap, a monetary cap on a benefit that we all agree
3 the greater use of it is better. There is cognitive
4 dissonance for me when we say we want to increase the
5 length of stay in hospice and then we have a benefit that
6 has a financial cap. Because what you are going to do is
7 have more and more people get up to the cap just before
8 they die and then get kicked out of the hospice. So it
9 just doesn't make any sense to me, if I understand that
10 there is in fact indeed a financial cap. So I would need
11 to understand better how that works. But to have a slide
12 that says there is a financial cap and --

13 MS. BOCCUTI: Let me say a couple things about
14 the cap. You're right, we haven't gone into a policy
15 analysis about the use of the cap. It came with the
16 benefit when it was first established to allay concerns
17 about it going widely out-of-control and being a budget
18 issue. It is not common to hit the caps, but it is
19 happening.

20 DR. ROWE: I would think it's happening with
21 that small proportion of the people with the very long
22 stays that are bringing up the mean.

23 MS. BOCCUTI: It's for one agency. It's on an
24 agency by agency basis, and it's their total number of

1 patients. So it's not an outlier.

2 DR. ROWE: I see. Maybe that was described in
3 detail. I missed it.

4 MS. BOCCUTI: So what it's saying is if an
5 agency hits the cap then their payments have exceeded the
6 cap.

7 DR. ROWE: I interpreted it, and I may not be
8 the only one, as a benefit cap on a beneficiary, so I
9 apologize.

10 I would agree that the managed care situation is
11 archaic and I think managed care companies are just going
12 to go develop better programs with respect to care at the
13 end of life. To whatever extent you want more Medicare
14 beneficiaries in managed care, that will be a problem.
15 But I would agree with that.

16 I do think that the last thing I'll say and we
17 said this before, the six months requirement, which is
18 basically asking people to walk through a door that says
19 over it, abandon hope all ye who enter here, is not the
20 way people think about themselves and their lives. A
21 hundred years ago when I was practicing medicine I would
22 say to people, you're not responding to these treatments.
23 It doesn't mean we won't keep trying. I'm talking to my
24 colleagues. Some other things may come up and we're going

1 to do everything we can, but it's time to start thinking
2 about what if you don't respond, and there are things that
3 you should be thinking about and talking with your family
4 about, and there are other approaches to treatment that
5 you might find helpful. You don't just say, sign this
6 paper.

7 MS. BOCCUTI: That is a unique eligibility
8 requirement to the Medicare hospice program. In private
9 plans they don't often require that kind of a signature.

10 MR. HACKBARTH: Here again, it was a provision
11 that was added I think strictly out of fear of the cost.
12 Sheila will know all of this firsthand.

13 MS. BURKE: Let me just go back to '83 when we
14 did this. The challenge at the time was that we really
15 didn't understand nor fully appreciate how people would
16 experience this benefit and how the benefit would be
17 utilized. There was little experience in this country.
18 Connecticut was one of the few places where it was
19 occurring. We looked to Great Britain for essentially a
20 lot of the stuff that was coming out of there, and there
21 were a number of fears.

22 One, there were tremendous fears about drugs.
23 There was this great issue we were going to create an
24 entire nation of heroin addicts. There was a tremendous

1 fear but what we didn't know about palliative care.

2 Secondly, there are a concern that people would
3 bounce. That they would choose this without acknowledging
4 that they were making a choice about this as compared to
5 curative care. There was a sense at the time that people
6 had to in fact -- that you needed to encourage people to
7 make those decisions. It was a crude way of doing that.

8 We also didn't really know what the timeframe
9 was, whether it was six months, whether it was two months,
10 whether it was a week, whether it was eight weeks. So
11 what you've seen over the years is a growing acceptance of
12 that as a method of care and a willingness to essentially
13 make these transitions, although the lengths of stay are
14 still too short. People tend to choose to late, for one
15 of the reasons you suggest, which is people hold out hope.
16 People want to know that there is in fact that
17 opportunity, and making that transition, making the
18 decision between seeking curative care and accepting and
19 making a decision to seek supportive care is a very
20 difficult one, so people don't make it, as you know better
21 than anyone.

22 So it was at the time an attempt to get a
23 benefit in place with little understanding of how people
24 would use it, and trying to control the fear around what

1 the cost would be, what the utilization would be, who
2 would choose it, why they would choose it. And also, that
3 you wouldn't literally have people this week do hospice,
4 next week decide they want to go back in traditional care.
5 So it was trying to create an environment in which that
6 bounding didn't take place.

7 We are way beyond that, and the refinements that
8 are suggested here, and a greater appreciation and
9 understanding clearly is what has to happen. But it was
10 done with the best of intentions given how little we knew
11 and our intention to do the best we could with what we
12 knew at the time.

13 MS. RAPHAEL: I think there is something else
14 that happened and it is not as prevalent today, but in the
15 last five to six years there has been a lot of OIG reviews
16 of the six-month requirement and a number of hospices were
17 cited for having cases that didn't fit in because the
18 physician had not prognosticated accurately, which is very
19 difficult to do anyway. I think that has had a chilling
20 effect which takes a longer time to dissipate than one
21 would think, even though that has receded and there's been
22 a CMS proclamation, go forth and don't be inhibited by
23 this unduly. I still see a lot of hospices being very
24 skittish about this particular requirement. So it's

1 almost become a more forceful part of the program in the
2 last few years.

3 MR. HACKBARTH: Do we have sufficient
4 information from outside the Medicare program, whether
5 it's private payers or other countries, whatever, at this
6 point, that we could say this requirement can be
7 eliminated without dire consequences, financial or
8 otherwise?

9 DR. ROWE: I've been looking at this recently
10 and I don't believe so. I think that what happened for a
11 long time is many health plans followed Medicare's
12 policies with their eligibility requirements, as they do
13 with respect to coverage of things. It's easy to defend
14 and who knew to do it differently. Now people at least in
15 our firm are starting to look at this a little
16 differently. I don't think we've accumulated enough
17 experience, but I think a reasonable policy recommendation
18 would be to change the six-month requirement on the part
19 of physicians to 12 months. Twelve months is really very
20 different and a might relieve some of the concerns that
21 Carol has just indicated.

22 I think that there could be a statement about
23 the fact that curative care could continue to be offered
24 but some recognition of the fact that you're in a

1 different stage. But this business about promising never
2 to ever let anybody give you anything that might be
3 interpreted as curative is just too much to ask people.
4 I'm sure there are people in the field, and I'm not in the
5 field, who have experience with this. But I do think
6 these recent cases have been a problem and I think 12
7 months would give us a lot more room.

8 MS. BURKE: I think there are a number of pieces
9 in this. One is the piece in terms of the determination
10 that you are seeking palliative as compared to curative
11 care and that conscious decision to sign off. The second
12 is the cap. The third is the six-month. You could
13 imagine modifying one of those without putting the others
14 at risk.

15 For example, you could go to 12 months, leave
16 the other pieces in place and begin to understand
17 adjustments to that and still probably not run the risk of
18 the program or the benefit going out of control. The
19 question is which of those pieces to move before you move
20 the other to see what the result would be. If that's the
21 great inhibitor at the moment, maybe doing that to 12
22 without removing the requirement they make a decision or
23 the cap, or just the cap based on some better
24 understanding of acuity, might be the way to begin to

1 manipulate those pieces without great risk.

2 MS. RAPHAEL: There's been much more erosion of
3 the demarcation between curative and palliative and I
4 think we've dealt with that. I don't think the cap is a
5 major barrier from my knowledge nationally. I think the
6 six-month is.

7 And one other point that you made I think is a
8 barrier, which is if you don't have a family member who
9 can participate, that is a barrier. We have many Medicare
10 beneficiaries who are widowed and don't have a family
11 member or don't have a child living in close proximity.
12 Anyway, I think that we should focus on the six-month
13 because I think that remains as the major issue.

14 DR. NELSON: Carol, you said that there has been
15 erosion of the demarcation between curative and
16 palliative. Would you clarify that for me? Use
17 congestive heart failure as a case in point, where it
18 might be damn hard to say what was palliative in terms of
19 medication.

20 MS. RAPHAEL: Congestive heart failure is a
21 problem for many reasons because you tend to have very
22 great difficulty in predicting what the length of lifespan
23 will be for congestive heart failure. That and
24 Alzheimer's patients are the most difficult to predict.

1 But I think in terms of using chemotherapy, it's no longer
2 prohibited to do chemotherapy for people who are in
3 hospice, and I think that's what I meant. So for cancer
4 patients there's less of these barriers.

5 DR. ROWE: But regardless of whether or not
6 Medicare prohibits it, you're still asking the patient to
7 sign a document which says -- and I don't think that
8 document has changed any in the last 20 years. So that's
9 the barrier that we're concerned about, less than the
10 clinical practice barrier. We need some advice about how
11 to handle that I think.

12 DR. REISCHAUER: In a sense the length and the
13 cap are redundant at some point. The longer you make it -
14 - if you say it can be up to a year -- the more likely it
15 is that the cap will be constraining rather than the days
16 will be constraining. So I think in a way --

17 DR. NEWHOUSE: No, because you can keep going
18 with successive periods of eligibility.

19 DR. REISCHAUER: But it's during a year. The
20 cap is for a year, average payment per beneficiary over
21 the year.

22 DR. NEWHOUSE: But as I understand it, the
23 proposal was --

24 DR. REISCHAUER: If the average rate got up at

1 175 days from 55 days I think we'd hit the cap.

2 DR. NEWHOUSE: But as I understood it, it was
3 just to ask the physician to certify that the patient
4 would likely die within a year. But that doesn't
5 necessarily mean that the average use is going to go up.
6 It puts the physician less at risk.

7 DR. REISCHAUER: You don't have to worry if the
8 doesn't. But if you're fearful that extending that time
9 is going to lead to growth in the average time span of
10 beneficiaries, then I'm just saying that there is a
11 connection between these two and you shouldn't get overly
12 worried. Just keep one. Or I'm not that worried about
13 your proposal is what I'm basically saying.

14 DR. ROWE: I'm not worried about worrying you
15 about my proposal. Because you don't want to spend the
16 money and I want the patients to be in the hospice.

17 DR. REISCHAUER: But we have to remember that
18 the latest RAND study suggests that people who participate
19 in this cost 12 to 18 percent more than those who don't.

20 MS. BOCCUTI: Depending on the diagnosis.

21 DR. ROWE: I thought it was 4 percent.

22 MS. BOCCUTI: That's overall. He had a
23 different diagnosis in mind when he was saying that.

24 DR. ROWE: Actually what he had in mind was that

1 I hadn't read the study.

2 [Laughter.]

3 DR. REISCHAUER: I thought you hadn't, and
4 neither had I, but we could then have a conversation about
5 it.

6 The other observation or question I'd like to
7 ask you is, with the Medicare drug benefit going into
8 effect, if we keep the payment system the same, in effect
9 aren't we boosting the margins of these entities? Because
10 one of the costs that they've been paying disappears or
11 not?

12 MS. BOCCUTI: The per diem payment always was
13 meant to cover the palliative care prescription drugs.
14 Now if a patient has drug coverage it doesn't mean that
15 they're going to go and get those drugs -- they might get
16 them elsewhere, but the benefit still covers the drugs.
17 So it's going to have covered it just as it did before the
18 Medicare drug benefit.

19 DR. REISCHAUER: But I was thinking, if I came
20 in and I was a member of this plan it wouldn't be paying
21 for the drugs?

22 MS. BOCCUTI: No. It's my understanding that
23 the hospice benefit would because that's always covered
24 the drugs anyway.

1 The only issued to bring up relative to the drug
2 benefit is that --

3 DR. REISCHAUER: So when you go into hospice
4 then you have to stop paying your premium?

5 MS. BOCCUTI: Unless you want it for non-
6 palliative care drugs.

7 DR. NEWHOUSE: Something else may happen to you
8 that you can in fact curative care for.

9 DR. REISCHAUER: Is this going to be
10 complicated.

11 MS. BURKE: The drugs in some cases are unique
12 enough that they're unlikely to be on a formulary that you
13 would use in the normal course. It depends on the nature
14 of the drugs used in the hospice. If they're pain
15 control, it would depend on what's in the formulary for
16 the basic drug benefit. You may still need things that
17 the hospice wouldn't in the normal course provide
18 unrelated to your --

19 MS. BOCCUTI: Right, if you have gout or --

20 MS. BURKE: Gout or any number of those things.
21 That would still be under the drug benefit.

22 MS. BOCCUTI: Maybe this is what you're saying.
23 The drug benefit, the person probably has higher cost
24 sharing than what's in the hospice benefit. The hospice

1 benefit is nil. So before the Medicare drug benefit there
2 was obvious financial advantage if the patient had a
3 terminal illness, there might be some incentive for them
4 to enroll in hospice to help with covering the oral pain
5 medications, if they didn't otherwise have drug coverage.
6 But that still may exist, and I have no data about the
7 demand relating to a drug benefit. But that could still
8 exist given that even if the person does have drug
9 coverage it's still more financially beneficial to have
10 their drugs covered in the benefit. So that's really the
11 only interplay between the two.

12 MR. HACKBARTH: Any others?

13 Okay.

14 DR. ROWE: What are we going to do, make
15 recommendations?

16 MR. HACKBARTH: Not at this point, but we'll
17 take this up next year and in our next cycle and then make
18 recommendations.

19 Okay, we're going to have a quick clause while
20 we change the mic here.

21 The last item today is chronic kidney disease.

22 MS. RAY: Good afternoon. Recall that at last
23 month's meeting, Joan, Karen, Rachel and I discussed with
24 you issues associated with implementing the chronic care

1 improvement program, Section 721 of the MMA. Also recall
2 that we will be including this analysis in our June 2004
3 report. We have revised the chapter to reflect your
4 comments from the March meeting, and please let Sarah
5 Thomas know if you have any additional comments.

6 In your mailing materials this month we included
7 in the revised chapter a case study on the potential of
8 care coordination services to improve the quality of care
9 for patients with chronic kidney disease. The last
10 portion of the chapter includes the case study, and our
11 objective for today's session is the focus in on this case
12 study.

13 So let me just go ahead and set some context
14 here. The target conditions set forth by Section 721 are
15 diabetes, congestive heart failure, and chronic
16 obstructive pulmonary disease. Chronic kidney disease
17 patients will most likely be among the participants of
18 this program, at least some of them. Diabetes is the
19 leading cause of renal failure. About 45 percent of
20 incident dialysis patients have diabetes, and about 30
21 percent have congestive heart failure.

22 Let me just to say here at this point that CMS's
23 RFP to implement Section 721, however, excludes patients
24 with end-stage renal disease. It does not exclude

1 patients however before they progress to end-stage, so
2 chronic kidney disease patients again will most likely be
3 included among the participants.

4 This case study discusses some of the issues
5 surrounding chronic kidney disease that policymakers may
6 want to consider when implementing Section 721. So one of
7 the questions that we try to address is, does care
8 coordination have the potential to improve the care for
9 these patients?

10 The other thing I wanted to mention was, why did
11 we choose chronic kidney disease for our case study? We
12 clearly could have selected other chronic conditions. We
13 selected chronic kidney disease because of the
14 Commission's longstanding interest in improving the
15 quality of care furnished to renal patients.

16 So let me define up front, what is chronic
17 kidney disease? People generally reach end-stage renal
18 disease as a result of chronic progressive kidney disease.
19 the national Kidney Foundation in their recent guideline
20 defines and divides chronic kidney disease into five
21 stages. That definition was included in the mailing
22 materials. Stage five is permanent renal failure, ESRD.
23 In stage three, the National Kidney Foundation recommends
24 evaluating and treating complications of chronic kidney

1 disease, and in stage four preparing patients for renal
2 replacement therapy. As I previously said, the
3 underlying disease that cause progressive kidney failure,
4 diabetes and hypertension, at least diabetes is clearly a
5 target conditions and these folks will most likely
6 participate in the program 721.

7 Why the interest in the potential of care
8 coordination for kidney disease? As the title mentions,
9 Healthy People 2010, one of its objectives is to reduce
10 new cases end-stage renal disease. ESRD, particularly
11 dialysis, is costly. Most patients who are ESRD are on
12 dialysis. There are approximately 300,000 dialysis
13 patients. Patients are hospitalized frequently -- about
14 twice a year -- and hospitalization and mortality rates
15 have remained high and relatively unchanged during the
16 past decade. ESRD patients fit the profile of groups who
17 might benefit from care coordination as well as chronic
18 kidney disease patients, as I will show you. And finally,
19 ESRD has a negative impact on patients' quality of life.

20 Our review of the literature suggests that
21 delaying or preventing end-stage renal disease may be
22 possible. It may be accomplished by better care of
23 complications of chronic kidney disease, like anemia, for
24 example. Also, better management of comorbidities like

1 diabetes and hypertension and other cardiovascular
2 conditions.

3 It's worth pointing out here that patients with
4 chronic kidney disease are more likely to die of
5 cardiovascular causes than to progressed to ESRD. It's
6 also worth mentioning here that there are several programs
7 that do focus on the pre-dialysis population. One in
8 particular is a large HMO in Southern California, and
9 another is actually an alliance, a western New York
10 alliance of insurers and providers. Both programs attempt
11 to identify chronic kidney disease patients when they're
12 in stage three and four and then refer them to a renal
13 team that's composed of nurses, physicians, dietitians and
14 social workers. The focus of the pre-ESRD care is on
15 complications CKD, including anemia, placing vascular,
16 particularly AV fistulas, on proper nutrition, better
17 management of comorbidities, and patient education.

18 Another reason we are interested in the
19 potential of care coordination is to better prepare -- and
20 this is during the pre-ESRD period -- those stage four
21 chronic kidney disease patients who will progress to
22 permanent renal failure. There's some evidence in the
23 literature to suggest that morbidity and mortality of ESRD
24 can be reduced if the comorbidities and underlying causes

1 are better managed.

2 Again, we're talking about here surgically
3 placing an AV fistula, which takes several months to do
4 so, and providing education about the different renal
5 replacement therapy options, including home dialysis and
6 kidney transplantation.

7 Your mailing materials reviewed some of the
8 literature that suggests that ESRD morbidity and mortality
9 is reduced for patients who are referred to a renal team
10 earlier. To examine the potential of earlier intervention
11 among chronic kidney disease patients we contracted with
12 Direct Research LLC to follow chronic kidney disease
13 patients in the one year prior and the one year after they
14 first started dialysis. The goal of the study was to look
15 at the use and services and spending based on the timing
16 of the patient's first visit to a provider with expertise
17 in nephrology, and Chris Hogan here will talk about the
18 benefits that he used to do so.

19 DR. HOGAN: My job was to find these people in
20 the claims and then track their costs and use of services.
21 You have to keep in mind when you look at the results,
22 this is a retrospective study. We started from the first
23 date of dialysis, then we looked backward to the pre-ESRD
24 period, and forward into the ESRD period to track service

1 use and costs.

2 Probably the most important bullet point on this
3 whole page is the next to the last. Mostly the only
4 people we can find are the elderly, and that's because if
5 you qualify for Medicare services based on ESRD only, you
6 start dialysis before you're on the Medicare program, we
7 can't see your claims. So we had to find people who were
8 already Medicare enrolled and then look at their claims
9 before and after dialysis.

10 To make this as clean as possible, we took
11 Medicare's official dataset that tracks end-stage renal
12 disease patients and matched it up against the claims to
13 make sure that we agreed with Medicare as to the initial
14 date of dialysis.

15 So Nancy asked me to look at a few indicators of
16 service, use and quality. Mainly we wanted to see whether
17 the patient was seen by a nephrologist before the onset of
18 end-stage renal disease, how soon before, how long before,
19 and then what happened prior to and after? Particularly,
20 did they get some kidney disease related treatments prior
21 to the onset of ESRD, and what happened to them after ESRD
22 began.

23 You have to keep in mind a few things. This is
24 sort of a rough-cut study. We looked for any mention of a

1 physician specialty that being a nephrologist and
2 physician specialty in Medicare is self-reported, so it's
3 self-reporting nephrologist. And if you had even one
4 visit we counted you as having had a consultation with a
5 nephrologist.

6 We have no way to make this population look like
7 the average incident ESRD patient because all we can do is
8 track the people who were already in Medicare before the
9 onset of ESRD. Probably most importantly, we did no risk
10 adjustment. This is how the claims shake out as you track
11 these people before and after the onset of ESRD. So we
12 didn't look for the comorbidities. And the numbers we
13 show you probably will not match anybody else's numbers
14 because it's a very unusual population in that it's very
15 elderly for an ESRD population. That's the only
16 population for whom we could find claims.

17 MS. RAY: So Chris classified our study
18 population into four groups based on the number of months
19 between their first visit to a nephrologist and the start
20 of dialysis. Those four groups are, they first saw a
21 nephrologist on or after dialysis, within 4 months before
22 dialysis, between four and 12 months before dialysis, and
23 more than 12 months before dialysis. So when I say late
24 referral patients I typically mean those folks who didn't

1 see a nephrologist until on or after they started
2 dialysis. And the early referral patients are typically
3 those that saw a nephrologist more than 12 months before
4 they started dialysis.

5 DR. REISCHAUER: Just a question, somebody who's
6 66 and has first dialysis at age 65 and six months --
7 you're shaking your head.

8 DR. HOGAN: Actually, to make it as clean as
9 possible, I required them to have two years of Medicare
10 entitlement prior to the onset of dialysis. So they
11 actually had to be 67 before they started dialysis.

12 DR. REISCHAUER: Conceivably they could have
13 seen a nephrologist at age 48.

14 DR. HOGAN: That's correct.

15 MS. RAY: That's right. This is just in the
16 period before dialysis.

17 DR. HOGAN: It's really the two years prior to
18 onset. And of course, if they were disabled they could
19 have been younger.

20 MS. RAY: Right. So I just wanted to reiterate
21 what Chris had said, that the results that we are going to
22 present to you are not representative of all incident
23 dialysis patients because of the selection methods that we
24 used. Our study population is older on average than all

1 incident patients.

2 Second, as Chris also pointed out, these results
3 are not adjusted for potential differences in demographic
4 and clinical characteristics between our four groups.

5 So this pie chart shows you that 40 percent of
6 all patients saw a nephrologist more than 12 months before
7 they started dialysis. That's the good news. The not so
8 great news is that 45 percent did not see a nephrologist
9 until four months before dialysis onset.

10 Chris also looked at when a patient first had a
11 claim for chronic kidney disease; that is, ICD-9-585,
12 which is chronic renal failure. 51 percent had a claim
13 with that diagnosis code more than 12 months before the
14 start of dialysis, and 18 percent had such a claim four to
15 12 months before the start of dialysis, and 28 percent had
16 a claim one day to four months before the start of
17 dialysis.

18 Finally, another interesting piece of
19 information I'd like to mention that Chris just ran out
20 for us is the diagnosis of chronic kidney disease overall
21 among the Medicare beneficiaries. What Chris did was he
22 identified patients with at least two claims for that ICD-
23 9 of 585 which we are using as a proxy for chronic kidney
24 disease, in a given year. So that diagnosis has increased

1 from 0.9 percent in 1996 to 1.6 percent in 2002.

2 Why is it increasing? The incidence of ESRD is
3 increasing somewhat. And it could also be due to the
4 increased awareness of chronic kidney disease.

5 DR. ROWE: Is that age adjusted?

6 MS. RAY: No.

7 DR. HOGAN: But it's a relatively short time
8 period.

9 MS. RAY: This is '96 to 2002.

10 DR. ROWE: The average age of Medicare
11 beneficiaries --

12 DR. HOGAN: Crept up a bit, but not very much
13 over that period.

14 MS. RAY: Some moving along to looking at the
15 use of services and outcomes of the study population. In
16 this table of contrasted service use and outcomes for the
17 early referral patients, those who saw a nephrologist more
18 than 12 months before dialysis and the late referral,
19 those whose saw a nephrologist on or after the start of
20 dialysis. You will stay differences in the proportion of
21 patients who received at least one medication for chronic
22 kidney disease complications like anemia or bone disease.
23 This would be an injectable medication. So it would be
24 erythropoietin, for example, for anemia.

1 Rates of hospitalization in the one month before
2 dialysis are high for both groups, but yet again are less
3 for early referral patients. Use of AV fistula at least
4 one month before dialysis is 30 percent for the early
5 referral versus 10 percent for the late referral patients.
6 Finally, there was a modest difference in mortality one
7 year after dialysis, 25 percent versus 30 percent.

8 Turning our thoughts to spending, we do find
9 modest differences in spending, \$32,000 for late referral
10 patients versus \$27,000, and that was spent in the year
11 prior to dialysis. Again, there is approximately a \$5,000
12 difference in the one-year after dialysis between these
13 two groups. You'll note that most of the difference in
14 the one year before dialysis stems from the inpatient
15 spending. Again that tracks back to the previous chart on
16 the rates of hospitalization in the one month before
17 dialysis.

18 Now this is spending for our entire study
19 population. This tracks spending on a monthly basis. So
20 minus 12 is the twelfth month before dialysis, and plus 12
21 is 12 months after dialysis. The minus one is that one
22 month before dialysis. You will see that spending peaks
23 in that month. When you look at this same bar chart,
24 separating out the early versus late referral patients,

1 the biggest difference you will see is in the month prior
2 to dialysis, particularly the inpatient spending.

3 So there's no surprise here that spending goes
4 up once they become dialysis, and we've already spoken
5 about the spike in inpatient costs in the one month prior
6 to them becoming end-stage renal disease. So then at
7 issue here is the potential of care coordination programs
8 to reduce the hospitalization rate before and even after
9 dialysis, and the impact on spending after the program
10 fees would be included in the analysis.

11 So let me make just a couple of brief
12 conclusions. The literature suggests that earlier
13 intervention and the better management of patients with
14 chronic kidney disease may in some cases delay or prevent
15 ESRD. Our results showed that -- again, our results are
16 not representative of all incident dialysis patients --
17 but earlier referral of CKD patients to a nephrologist may
18 reduce the morbidity and mortality associated with ESRD.
19 Care coordination programs as configured under the law may
20 provide opportunities to promote earlier intervention and
21 improve management of stage three and stage four chronic
22 kidney disease.

23 Next steps that we could think of include
24 evaluating how well the contractors of 721 improve the

1 outcomes of patients with chronic kidney disease, and to
2 examine the potential of different care approaches to
3 improve the quality of care for these patients.

4 We'd be happy to take comments about this topic.

5 DR. REISCHAUER: This is going to sound a little
6 gory. When we are comparing the costs, I'm wondering
7 should you take out the cost associated with the people
8 who died? The point is, if you looked at this over two
9 years and you kept the panel the same then they would have
10 zero cost in year two and that's not the way one wants to
11 look at whether Medicare is getting a benefit or not from
12 this. But if you think there's the last year of life
13 problem and every Medicare beneficiary is going to face it
14 sometime. Chris, you've probably thought about this a lot
15 more than I have.

16 DR. HOGAN: I can offer some comments. One, of
17 all the Medicare beneficiaries with high end-of-life cost,
18 ESRD patients have the highest. They almost always die in
19 the hospital, so end-of-life costs are very important for
20 this population. My second thought was, the elderly ESRD
21 patients have an astronomical mortality rate, 30 percent a
22 year die in this population. The average for all ESRD is
23 about 17 percent, and the younger ESRD is about 12
24 percent. So to have struck the elderly who died from the

1 cost series entirely -- once they die we don't count them
2 in the denominator anymore, so we don't let the average
3 cost trail off with a bunch of zeroes on the end. We do
4 take the months post-death out of the denominator when we
5 calculate our rates.

6 But it seemed like such an important component
7 of cost that it was a judgment call to leave them in, but
8 it seemed like a reasonable judgment call to leave them
9 in. We could certainly rerun the numbers, exclude the
10 decedents. You'll see a lot lower series, but I'm not
11 sure that that's the more relevant series.

12 DR. ROWE: A couple questions. I think this is
13 great that we're doing this, obviously. Why didn't you
14 include transplant? The really elegant way to handle
15 these patients is never to have them dialyzed but to have
16 them go right into a transplant, if they're seen well
17 enough ahead of time and get the work -- so I'm talking
18 about patients who were transplanted but never dialyzed.

19 DR. HOGAN: Never came up.

20 DR. ROWE: Because that's really the way to do
21 it. You have a family member who wants to donate. The
22 patient's renal failure is getting worse. Dialysis is
23 terrible, so you transplant the patient.

24 MS. RAY: I had considered that, and we can

1 certainly do that.

2 DR. ROWE: Good; thank you.

3 MS. RAY: But we did put in rates of peritoneal
4 dialysis, and you'll notice with those rates of peritoneal
5 dialysis how much lower they are than all incident
6 dialysis patients, again because of the age of our
7 population. We're dealing with folks who are much older
8 on average than your incident population, so rates of
9 kidney transplantation will be even lower among our study
10 population. That was my one thought of why I did not
11 choose to do that, but we certainly can. It's worth
12 looking at.

13 DR. ROWE: If you're looking at care management,
14 I think that whether they were seen by a nutritionist,
15 which there should be a claim for, would be a good
16 measure.

17 DR. HOGAN: That benefit only got covered
18 recently. So it's such a long time series to pool enough
19 people to find --

20 DR. ROWE: But if you an epoch of the data in
21 which it's covered, because the thing that the
22 nephrologist does, after confirming that you have chronic
23 kidney disease, is send you to a nutritionist so that you
24 can start to get on the right diet, which is really what

1 it's all about, and then controlling your blood pressure
2 obviously. So that would be a nice marker.

3 The third is, I think one problem with the logic
4 here, and you're very smart and I'm probably wrong here
5 but that's okay, I'm not easily embarrassed. You noticed
6 that 25 percent mortality in the year after dialysis
7 started in the ones that had been seen by a nephrologist
8 and a 30 percent in the ones that hadn't, and you come up
9 with a statement that says there may be a benefit to
10 mortality. But let me see if I got this right. If you
11 see a nephrologist early then you're likely to be put on
12 dialysis earlier. That is, if you didn't see a
13 nephrologist until the time that you start dialysis or
14 afterward, I bet your creatinine is higher when you're
15 starting on dialysis than if you had seen a nephrologist a
16 year or two ahead of time and they were watching and
17 waiting.

18 If it's year after the start of dialysis and
19 dialysis is beginning earlier, then you would expect a
20 lower mortality rate in that first 12 months because the
21 people aren't as far advanced and as sick. So there's
22 something wrong with my logic and you tell me what it is.

23 DR. HOGAN: I'm absolutely amazed that we have
24 numbers that show that it's much better to be referred to

1 a nephrologist and you're disagreeing with us.

2 DR. ROWE: I'm an insurance salesman. I used to
3 be a nephrologist.

4 [Laughter.]

5 DR. HOGAN: But the logic is it is very
6 difficult to draw a causal inference out of --

7 DR. ROWE: If you have the serum creatinine
8 values, I would bet that the serum creatinine at the
9 outset of the dialysis under people who saw a nephrologist
10 ahead of time is lower. So I would take this statement
11 out about the mortality. I don't think you can say
12 anything about mortality.

13 DR. HOGAN: This is as another tough call
14 methodologically because it was a retrospective study.
15 Your point is well taken. We took a crack at finding all
16 the CKD patients and then thinking of running -- at least
17 to find the prevalence and running forward to see what
18 happened to them. That would be a different study to do
19 that.

20 We also took just an informal look at not risk
21 adjustment, per se, but looking at a lot of values for the
22 patients who saw the specialists and who didn't and it
23 looked like the specialist was seeing the sicker patients.
24 So perhaps we could resolve this with a little more risk

1 adjustment to try and figure out --

2 DR. ROWE: Up until you do a little more I would
3 stay away from statement, because -- you may be right but
4 we're really not confident that you're right until we do a
5 little more study.

6 DR. NEWHOUSE: I agree with Jack. I think
7 there's going to be a temptation to interpret it causally
8 if it's out there.

9 I had a picky, technical comment and a picky,
10 technical question. On the power cancellations, which it
11 looks like Chris did, the picky, technical comment is we
12 should say what the assumption is on type II error, which
13 wasn't there.

14 DR. HOGAN: Yes, I believe that's correct.

15 DR. NEWHOUSE: The question is, you show samples
16 that would be needed for inferences in later years, and to
17 do that you need the intertemporal correlation, unless
18 you're just using the actual year to year spending.

19 DR. HOGAN: This is such a hard question.

20 MR. HACKBARTH: I was going to ask you the same
21 thing if Joe didn't.

22 [Laughter.]

23 DR. HOGAN: We can go down this path but it
24 leads to all sorts of very difficult --

1 DR. NEWHOUSE: I know, but it turns out that
2 even seemingly relatively small intertemporal correlations
3 matter a lot for power calculations.

4 DR. HOGAN: Yes, the power calculation that you
5 saw was one year at a time, period.

6 DR. NEWHOUSE: That's what I suspected.

7 DR. HOGAN: It was the simplest possible thing
8 to do. It is not clear how the care coordination demo is
9 going to be evaluated. The potential impact of care
10 coordination on the mortality rate makes it a very
11 difficult thing to evaluate, because if I've suppressed
12 the mortality rate in year one I'm left with --

13 DR. NEWHOUSE: No, it's not the mortality rate.
14 I'm willing to let you assume that the mortality rate --
15 maybe I shouldn't. You're saying you don't want to assume
16 the mortality as independent of the rate of spending.

17 DR. HOGAN: I don't know what to assume, and
18 I've asked a lot of people and I haven't got a good
19 answer.

20 DR. NEWHOUSE: You can get a number on the
21 intertemporal correlation. That's not hard to do. And
22 you can put that into a power calculation. But then to
23 make sense of it you would need some kind of Independence
24 assumption and that's probably not there. But the number

1 that's here is not right either. Maybe you just don't
2 want to do the downstream, the second year after start,
3 third year after start, numbers.

4 DR. HOGAN: I'm sorry, tell me why that number
5 is not right.

6 DR. NEWHOUSE: Because basically observing two
7 people for each of one year is better than observing one
8 person for two years because they're not independent.

9 DR. HOGAN: Yes, so what I --

10 DR. NEWHOUSE: And you're observing the same
11 people going forward.

12 DR. HOGAN: Right. I completely admit to doing
13 the simplest possible thing and to ignoring that. But I
14 never got clear direction even from the Federal Register
15 notice as to whether the evaluation is going to be done on
16 were your costs in year three separate from -- I think I
17 must be misunderstanding what you're asking.

18 DR. NEWHOUSE: No, I'm assuming that somebody is
19 going to want to know the episode cost.

20 DR. HOGAN: The cumulative three-year cost is
21 what you would rather have seen?

22 DR. NEWHOUSE: Yes.

23 DR. HOGAN: I would love to do that calculation.
24 And you want to see that in the report as opposed to a

1 year at a time?

2 DR. NEWHOUSE: The one year will be the year at
3 a time, but, yes.

4 DR. HOGAN: You would like to see the three
5 years cumulative done properly.

6 DR. NEWHOUSE: Yes, because if you are doing one
7 year at a time on the same people, those calculations are
8 not independent.

9 DR. HOGAN: Yes. I will take that as the go-
10 ahead and go and do that.

11 DR, MILLER: Can we get an estimate on how much
12 it's going to cost to find this out?

13 [Laughter.]

14 DR. STOWERS: I may be jumping ahead here too,
15 but when we looked at what the cost was for a year and
16 that kind of thing, it seems like to me what we're looking
17 at from a cost standpoint is the cost-effectiveness of
18 chronic care management or chronic disease management. So
19 we've got X number of dollars here, if we take that to the
20 final step what would be the cost that was added on to
21 Medicare if this patient had been in some type of a
22 managed care program or management program or whatever?
23 Because it's the net net that's going to make a difference
24 here at to whether it was a cost effective thing for the

1 Medicare program to do or not.

2 So I think if we don't take this logic to the
3 next step in this chapter somehow then it's not been much
4 guidance as to whether or not this was a good program to
5 have or not to have. Only from cost, not from quality of
6 care or whatever. But I think we need to somehow make
7 that last step at least in some kind of a discussion that
8 everything you see here in savings is not savings, if in
9 fact they've been in a new added-on expense chronic care
10 program. So we're taking a glance at this chart like we
11 just saved \$5,000 here. But we haven't because we've
12 incurred a new expense by contracting with these
13 individuals or whatever company or management company or
14 whatever.

15 DR. MILLER: I think I follow your point. We
16 shouldn't be talking about this as clear savings if our
17 hypothesis is that somebody is going to need some kind of
18 management. There's a cost to that.

19 MS. RAPHAEL: I was wondering how you were going
20 to examine the potential of different care coordination
21 models? Because I think in a way this is a microcosm of a
22 group for whom the now classical disease management will
23 not apply, where you really do need some different models
24 given the complexity of this population. We know that

1 it's not out there. We don't know with the CCIO to what
2 extent we'll really get some of the models, what they're
3 now calling case management models. So I was just
4 wondering what your approach is going to be?

5 MS. RAY: That's a good question and this is
6 clearly something for the future that we would sit down
7 and think about. As a first step, there are a few
8 programs out there that do focus in on the pre-ESRD
9 population and do provide some care coordination for that
10 population, so would clearly be a first step.

11 To be honest with you, in my search of the peer-
12 reviewed literature I did not find any studies with any
13 kind of statistical analysis on the pre-ESRD population
14 showing the benefits of such programs. But that will
15 definitely be a challenge.

16 MR. HACKBARTH: Anyone else?

17 Okay, thank you very much.

18 That concludes this afternoon's session. We'll
19 have a very brief public comment. I'd ask you to confine
20 your comments, if you have any, to things that we
21 discussed this afternoon or this morning.

22 [No response.]

23 MR. HACKBARTH: Okay, hearing none, we will
24 reconvene tomorrow at 10:00 a.m. For those of you who are

1 used to 9:00, it is 10:00 a.m. the public session
2 tomorrow.

3 [Whereupon, at 4:30 p.m., the meeting was
4 recessed, to reconvene at 10:00 a.m., Friday, April 23,
5 2004.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 23, 2004
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

	231
AGENDA	PAGE
Sources of financial data on Medicare providers -- mandated reports	
-- IRS form 990	227
-- Nancy Kane, Harvard School of Public Health	
-- Data needs and sources	259
-- Craig Lisk, David Glass, Jeff Stensland	
Work plan for MedPAC's specialty hospital study	296
-- Julian Pettengill, Carol Carter	
Public Comment	312

1 P R O C E E D I N G S

2 MR. HACKBARTH: I'm sure Craig is going to
3 introduce not just the topic but the speaker, as well.
4 but Nancy, welcome. Nancy and I knew each other a little
5 bit in Boston and had a few occasions to talk. So it's
6 good to have you with us.

7 MR. LISK: I'd like to introduce you to Nancy
8 Kane, Professor of Management in the Department of Health
9 Policy and Management at the Harvard School of Public
10 Health.

11 Dr. Kane's research is focused on financial and
12 managerial performance of health care organizations.

13 Today she is going to discuss her work on IRS
14 form 990 as a data source for reporting on hospital
15 investments, endowments and access to capital. This is
16 one of two reports mandated by the MMA that are due June
17 1st of this year which the Commission will be discussing
18 this morning.

19 After you're through with the discussion of the
20 990 project with Dr. Kane, David, Jeff and I will discuss
21 the other Congressional mandated report on the need for
22 and sources of current data to determine the solvency and
23 financial circumstances of Medicare providers.

24 DR. KANE: Thank you, Craig. Thank you

1 Commissioners and Mr. Hackbarth.

2 It's a pleasure to be here this morning to talk
3 about a subject that I probably know a lot about it and
4 you probably don't want to know too much about. So I will
5 try to keep it brief brief. But I guess Congress is
6 interested in monitoring the financial health of hospitals
7 and understanding the impact of not just Medicare but
8 other forces on the hospitals' financial condition, and
9 obviously is looking to the 990s as one of the major
10 sources of information.

11 So what I'm going to try to do today is give you
12 some idea of how valuable and not so valuable at times the
13 990s are as a source of information on these fairly
14 critical issues, and I think becoming increasingly
15 challenging to understand.

16 Just keep in mind, the 990s' purpose is an
17 informational document required by the IRS and it's used
18 by the IRS and some state oversight agencies like the
19 attorney generals in charge of charitable assets in a
20 state. It's used by donors. It's often read by the media
21 more than anybody else. In fact, that's where a lot of
22 the attention is paid to charitable organizations. It's
23 often the journalists trying to learn how to read these
24 things. I have given many sessions, in fact, teaching

1 journalists how to read these things.

2 But their main purpose is to decide whether the
3 organization continues to meet requirements for tax
4 exemption and that's quite a different purpose than trying
5 to ascertain financial stability. Many of these
6 organizations are small and oriented towards non-health-
7 related activities. So again, a very different focus than
8 what you might want to know about in a hospital. And
9 that's where some of the issues come up when you try to do
10 financial analysis. And I will be explaining those in
11 more detail in a few minutes.

12 The good news about the 990s is the public
13 disclosure has expanded a lot in recent years, since
14 around '96 when the IRS began to require that charities
15 put their 990s in a public domain and the GuideStar web
16 site came into being and therefore people have access to
17 them without having to go to the organization and stand
18 there and beg for the form 990, which I used to have to
19 do.

20 Who reports? All tax-exempt organizations with
21 greater than \$25,000 in gross receipts, excluding
22 churches. Hospitals that are religiously affiliated do
23 report so they're not exempt. But this means more than
24 220,000 public charities and 60,000 private charities file

1 some version of the IRS form 990. It's a lot of
2 organizations, a lot more than the IRS can possibly audit
3 or even review in any one year.

4 The types of information included on the 990s,
5 it's a six-page form plus up to 40 or 50 pages of
6 attachments. There are 105 items that are specified and
7 requested in the forms, and there's 45 pages of
8 instructions. So it's a lot of data around the revenue
9 expenses. That would be sort of like an income statement,
10 functional expenses. Again because of charitable purpose
11 there's a real interest in the division of expenses
12 between what the charity program is comparing to the
13 management expenses and the fundraising expenses.

14 There is a disclosure of program service
15 accomplishments. There's sort of a balance sheet. I'm
16 saying sort of because my standard, by the way, is the
17 audited financial statements that are governed by
18 generally accepted accounting principles. So when I sort
19 of devalue a little bit the 990, it's because it doesn't
20 quite come up to the generally accepted accounting
21 principles version or the audited financial statements.

22 It also discloses compensation because of the
23 charitable issues involved with inurement that the IRS and
24 others are interested in. And one of the most valuable

1 things the 990 does is it lists all of the affiliates and
2 subsidiaries of the entity that's reporting. We'll come
3 back to that, though because that actually makes it hard
4 in other ways to understand the financial condition of the
5 hospital.

6 That's sort of an overview of the 990s. Now I'm
7 going to get into the specific question of how valuable is
8 the 990 as a data source for reporting on investments and
9 endowments. One of the first things you might want to
10 know is how well do they report information you need to
11 know about investments and endowments? Under generally
12 accepted accounting principles, investments are broken up
13 into these various categories that are used differently
14 depending on where they're coming from. So there's
15 restricted and unrestricted is the first category, where
16 unrestricted is available for general operating purposes.
17 Restricted it is restricted by donors.

18 The management of a hospital cannot use donor
19 restricted investments for any purpose other than the
20 donor specified purpose. So those assets are not
21 available to meet an operating deficit or repay debt or
22 any of the general operating purposes of the organization.

23

24 Their unrestricted assets are broken up into

1 operating cash, board-designated investments which are
2 amounts of securities that the board has said should be
3 used, usually for capital purposes. They can also
4 undesignate them, so they are considered available for
5 general operating purposes.

6 And then a third category is trustee-held
7 investments which are investments set aside under some
8 sort of contractual arrangements such as debt service
9 funds or self-insurance funds.

10 Only the top two categories of unrestricted
11 funds, operating cash and board-designated cash, are
12 commonly used to create ratios that creditors would look
13 at for the availability of cash or days cash on hand as
14 part of assessing hospitals' financial health. So you do
15 need to be able to segregate out these categories to do an
16 effective analysis of hospitals' liquidity and days cash
17 on hand.

18 The bad news is in the 990 none of these
19 categories are recognized. All investments are reported
20 on one line item on the balance sheet. So sometimes it's
21 disclosed in the attachments but the attachments, as I
22 say, do take a little more time and are rarely collected
23 in any kind of automated form.

24 Another issue around investments, and one reason

1 you might be interested in investments is that they
2 generate income. And the income generally comes in three
3 different classifications. If you look across the top of
4 my slide, the top row, there's dividends and interest
5 income, there's realized gains and losses which is
6 basically what you realize when you sell the asset for
7 above or below cost. And then there's unrealized gains and
8 losses which is the fluctuations in market value of
9 investments that you continue to hold.

10 Under generally accepted accounting principles
11 investment income hits the income statement or not
12 depending on which type of investment it comes from. So
13 if it's an unrestricted investment it hits the income
14 statement unless it's unrealized gain and loss, in which
15 case it does not hit the income statement.

16 DR. ROWE: I'd like to ask a clarification,
17 because I just remember things as being a little different
18 than the way you stated them, Nancy. so maybe you can
19 clarify this for me.

20 I was under the impression that for a restricted
21 gift of an endowment that, perhaps depending upon the
22 language of the deed of gift, capital gains on the corpus
23 can in fact be used for unrestricted purposes. And
24 therefore, would appropriately be included by rating

1 agencies and others when they're looking at the financial
2 stability of an organization.

3 DR. KANE: Depending on how detailed you want me
4 to get. You're absolutely right, some donors do stipulate
5 that their endowment is to be set aside in perpetuity.
6 But some of the return may be used for general purposes.

7 But it's not all.

8 DR. ROWE: Some organization that gets to be
9 most of the --

10 DR. KANE: That's correct.

11 DR. ROWE: So in a restricted category --

12 DR. KANE: Unfortunately, that's the general
13 notion. There are states that allow hospitals to keep all
14 of that in a restricted account and have all of the income
15 accrue to a restricted net assets until management chooses
16 to use it. So it will go back and forth. You have to be
17 able to read the footnotes, let me put it this way, to
18 know when the restricted asset income can be moved into
19 unrestricted.

20 So in general, and I'm really trying to keep it
21 general, depending on where the investment income is
22 coming from it either hits the income statement or it
23 doesn't. If it doesn't, it hits the change in equity,
24 change in net assets. And that's an important distinction

1 in terms of determining, for instance, your excess revenue
2 or your bottom line.

3 Unfortunately, the 990 doesn't keep that
4 distinction clear. So there are many times when the 990
5 is looking at income that should have just been a change
6 in net worth or net equity in the donor-restricted assets
7 that it classifies as income that goes into what you would
8 call your income statement.

9 And that's one of the biggest problems with the
10 990. If you want to know the bottom line, you've got a
11 mixture of restricted and unrestricted revenues in there,
12 and you need to know exactly which ones should go on the
13 bottom line.

14 I've compared these to audits and it's often
15 off. In fact, I'll give you an example of that.

16 MR. HACKBARTH: Thanks, Jack, for the question.

17 Just one reminder before Nancy proceeds.
18 Because of the statutory deadline for this report, which
19 is June 1 of this year, this is going to be the only time
20 that we discuss these matters. So it's even more
21 important than usual that if you have questions or you
22 have concerns, this is going to be your opportunity to get
23 them clarified in we're fortunate to have Nancy here to
24 help us do that.

1 DR. KANE: So I won't be counted against going
2 over my time?

3 I think just to show you how important
4 investment income is and understanding where it's coming
5 from and how much it is, this is a charge of a state that
6 I generated from their audited financial statements, not
7 the 990s. And what this shows you is the excess revenue
8 for all the hospitals in this state for the period '98
9 through 2002 from their audited financials.

10 What I want you to notice is how much of a
11 difference investment income makes in the level of excess
12 revenue, which is the numerator by the way of your total
13 margin figure, which I know you'll be talking about again
14 in a little bit.

15 So one of the things you might notice from this
16 chart is that investment income was driving the excess
17 revenue right up through 2000. And then suddenly, you
18 know right when the stock market doesn't do too well.
19 2001, 20002 investment income practically disappears.

20 In that sense, the total margin would make these
21 hospitals look worse over this period. However, the green
22 is their operating income which is the result, basically,
23 of their patient service mission. And you see it rising
24 over this same period.

1 So if you're just looking at total margin,
2 you'll think oh, they're doing worse over this period.
3 But if you're concerned with how the third-party payment
4 system is operating or how the patient care mission is
5 doing, you get the exact opposite impression.

6 So again, this is just to explain how important
7 it is to be able to pull out investment income and
8 understand its impact on the bottom line.

9 I'm going to take this year 2002 --

10 MS. ROSENBLATT: Nancy, I'm sorry.

11 When you're using the term investment income,
12 are you only counting what's coming in? Or is it net of
13 what might be going out? Interest expense.

14 DR. KANE: It's before interest expense, which
15 is actually an operating expense. There may be some other
16 nets against it that relate to the cost of managing the
17 investment fund but it's not counting interest expense
18 that you use to service your debt.

19 Let's look at 2002 for a minute. You'll notice
20 that investment income has practically disappeared and
21 that other non-operating revenue is negative. I just want
22 to give you a sense of the magnitude of what's underneath
23 those numbers, and to help you to see why it's important
24 to be able to pull out investment income and its various

1 categories.

2 This is that 2002 of that state. And you can
3 see that contributions are positive but investments and
4 other entities, they're losing cumulatively about \$5
5 million that year. Interest and dividends generated \$31.8
6 million but that was almost entirely offset by realized
7 and unrealized losses. That's basically the effect of the
8 stock market drop in 2002. So they end up having negative
9 non-operating revenue.

10 But again, if you're trying to assess the
11 performance of an organization, it really does help to
12 understand where the negativity is coming from. And here
13 you can see very much it's related to the drop in market
14 value of investments.

15 The next issue I wanted to talk about is capital
16 access. And these are measures of capital access by
17 financial stability. This is the same state that I've
18 been showing you all along. And as of 2000 we had roughly
19 seven years of data on these hospitals. What I've done is
20 pull out seven of the key ratios that one would look at to
21 determine capital access.

22 What I've also done is categorized these
23 hospitals based on seven years of data as to whether they
24 were distressed, whether they had red flags, which meant

1 they had some bad things in their performance that you
2 would worry about as an analyst, whether it looked like
3 they had barely sustainable performance or whether they
4 looked advantaged, like they were had very strong
5 financial performance and it gave them a competitive
6 advantage.

7 This is one state. This is not, by the way, a
8 typical state necessarily. I don't know what a typical
9 state looks like because we don't have a national dataset
10 that does this this way. But it gives you a sense, by
11 categories the hospitals this way, how these seven ratios
12 differentiate across varying degrees of financial
13 distress. And it helps you understand why these ratios
14 are quite useful to have if you're going to assess access
15 to capital.

16 What you see, very clearly, total margin pretty
17 much correlated with the financial stability or
18 instability, operating margin also very much correlated.
19 Days in accounts receivable which is, by the way, one of
20 the ratios that you can get from the 990 pretty cleanly,
21 does not differentiate much across these four categories
22 in this particular state. This is really how fast are you
23 collecting your revenue. It doesn't look like the
24 financial instability in this state is caused by slow

1 payment.

2 Days cash on hand, very closely related to
3 financial status. Again, you can't calculate that, as I
4 mentioned before, because of the poor categorizations on
5 the 990 of investments.

6 Equity financing, which is a proportion of your
7 total assets financed by equity, pretty much correlated
8 and you can get that from a 990 reasonably well. It's
9 actually close to the audited.

10 Debt service coverage you cannot get from the
11 990 but it's a key ratio used by creditors and you can see
12 again it's highly correlated with financial status.

13 Average age of plant, you can get from the 990
14 and it does show a relationship with the financial status
15 categories.

16 DR. ROWE: Nancy, I'm a little concerned if a
17 table like this is going to appear in the MedPAC document
18 because it indicates that MedPAC feels that an operating
19 margin of 1 percent is sustainable, makes an institution
20 sustainable.

21 These are not-for-profits, so there's no tax and
22 presumably not many hospitals pay payments in lieu of
23 taxes. But there are capital expenditures that are
24 required. I just don't see 1 percent as being

1 sustainable, maybe necessarily. We get into a lot of
2 arguments about what the margin should be when we try to
3 figure out what the payment adjustments should be.

4 If we're going to publish this, I don't want it
5 out there for people to reference as MedPAC's definition
6 of a sustainable hospital.

7 DR. KANE: That's really up to you how you want
8 to categorize it. I will say a 5 percent total margin
9 does help and so does an eight-year-old plant, which is
10 right about the national median.

11 DR. ROWE: But the operating margin on the slide
12 is 1 percent. And I don't think it's sustainable. You
13 can't sustain an institution and make any capital
14 investments over time at 1 percent in my mind, in my
15 experience.

16 DR. KANE: Well, these places have actually
17 survived and are still doing very well in 2002.

18 DR. REISCHAUER: Why can't you? They have a lot
19 of investment income and they choose to use that for good
20 purposes.

21 MR. MULLER: But Nancy said, we don't know what
22 is a representative sample, and so forth.

23 DR. ROWE: They don't have a lot of investment
24 income. Most of their endowment is restricted.

1 DR. REISCHAUER: I'm saying they may or they may
2 not. And I don't think we really know.

3 DR. ROWE: You can't tell from that, but there
4 are hospitals, and Ralph's may or may not be one of them,
5 that would find a 1 percent operating margin to be the
6 only source they had of capital for IT improvements or
7 other kinds of changes in a market that demands those
8 kinds of changes.

9 It just seems like a definition that maybe it's
10 the right definition. But I'm not sure we've discussed it
11 here at MedPAC.

12 DR. NEWHOUSE: But isn't that a question of how
13 we just labeled the columns?

14 DR. ROWE: Absolutely. Maybe you want to call
15 it stable.

16 DR. NEWHOUSE: Should there be some indication
17 of the range or variability within each of the columns?

18 DR. KANE: That's fine. I can do that.

19 DR. ROWE: For the purpose of this analysis, but
20 it could be used for a different purpose. That's all.

21 MR. HACKBARTH: I'm not sure whether there is an
22 intent or not to include this particular table in a MedPAC
23 report. The way I understand it is Nancy's using this to
24 try to illustrate to us what's available on the form and

1 how well it correlates with different levels of financial
2 performance. And what label you attach to them, we don't
3 need to focus on right now.

4 Your point is well taken though. I hear you.

5 DR. KANE: Any other questions about these
6 ratios and what they mean? And the fact that only three
7 out of the seven are available in a reasonable way out of
8 a 990.

9 I wanted to give you an example of, a comparison
10 actually, of a 990 versus the audited financials. And for
11 good measure we threw in the Schedule G from the Medicare
12 Cost Report, which you may or may not want to talk about
13 today.

14 What you see here on the income statement of
15 this very large teaching hospital is the net patient
16 service revenue across the audit, the 990 are close. The
17 Medicare Cost Report, for some reason, has a lower net
18 patient service revenue. And that can be for a lot of
19 reasons that I won't go into today, but I did write a
20 whole article about that, if you want to read it some day.

21 But where the 990 has real discrepancies with
22 the audit is under other operating revenue. And that's
23 the problem of the mixing of restricted and unrestricted
24 revenues where it's putting into the income statement

1 revenues that the audits say do not belong there. They
2 belong as a change in net assets in a restricted account.

3 What that does, if you scroll on down to the
4 operating income, it throws the operating income off by
5 about \$20 million and makes it look better in the 990 than
6 it is in the audit.

7 Now some of you who are looking at the Medicare
8 Cost Report column are probably saying wow, look how close
9 the Medicare Cost Report is on the operating income. And
10 that's great and once in a while that happens.

11 But then if you keep on going down below the
12 operating income, here's where the Medicare Cost Report
13 gives you trouble. It doesn't properly classify the
14 investment income. It calls it a donation, a
15 contribution.

16 And then if you get to the bottom bottom line,
17 excess revenue over expense, the 990 continues to be off
18 by \$20 million because it's got restricted revenues mixed
19 in there. But the Medicare Cost Report had this other
20 unfortunate area called other expense in which they put in
21 capital donations and other changes to net assets that
22 don't run through an income statement. But they ran
23 through the income statement on the Medicare Cost Report.
24 So you end up about \$25 million off on the Medicare Cost

1 Report in the bottom line.

2 Okay, these are little numbers on a percentage
3 basis. The audit gives you an operating margin of minus
4 1.4 percent and a total margin of minus .1 percent, both
5 of which are below that state's median operating and total
6 margin. The 990 does not look a heck of a lot better
7 except that it raises this hospital into the top half of
8 performers in their state. And the Medicare Cost Report,
9 it depends on which number you want to pick, where they
10 land relative to the state median.

11 So these are small numbers. People say so what,
12 it all comes out in the end. But actually, if you're
13 really trying to do financial analysis and compare it to
14 their peers or their state or national data, even these
15 small numbers that are operating income and total margin
16 make a difference. Therefore, it is better to have
17 something accurate in trying to understand your bottom
18 line, your total margin and your operating margin.

19 Another hospital that is much smaller shows
20 that small classifications can make a huge impact. This
21 is a critical access hospital. Obviously people are
22 concerned about their operating performance and how well
23 they're doing. They've been deemed an essential community
24 hospital. If you look at operating income on the audit

1 they make \$800,000. If you look at it on the 990, they
2 lose \$39,000 as it relates to how they've classified their
3 expenses. And they are obviously not the same
4 classification, whatever reason. It turns out they have
5 the same total margin but a very different operating
6 margin.

7 So if you look at the operating margin under the
8 audit it's 5.8 percent. One would conclude -- I think
9 even maybe Dr. Rowe would conclude -- that's probably
10 sustainable. But if you look at the 990, you go that's
11 not sustainable. It's minus .3 percent.

12 So again, the classifications of your expenses
13 and your income really need to follow generally accepted
14 accounting principles to get a comparable and sustainable
15 read on what's going on.

16 There are other issues around 990s that are
17 important to appreciate. One is that they don't report
18 any faster than the Medicare Cost Report in terms of
19 coming out. They are allowed to report five months after
20 the close of the fiscal year and many of them request
21 extensions and so you don't get them until eight or nine
22 months after the fiscal year. If you're relying on
23 GuideStar it's usually a two-year lag.

24 So in 2004, right now, I'm able to get most of

1 the 2002s when I go in and look for a particular hospital.
2 So not an improvement over the Medicare Cost Report.

3 In terms of reporting inconsistencies, there's a
4 lot of variability in the completeness and the accuracy,
5 although the GuideStar disclosure has helped enormously
6 because now they know someone can actually get access to
7 these things and read them. But the problem is the IRS
8 really can't enforce any kind of reporting consistency.
9 Their audit staff reviews .43 percent or less 1 percent of
10 charitable 990 filings and it's pretty impossible. And
11 they're mostly looking for whether they're compliant with
12 charitable requirements, not whether they're financially
13 stable or have accurately reported their income statement
14 and balance sheet elements.

15 In terms of electronic availability, the
16 GuideStar is great but it's one by one by one, with again
17 the 40 to 80 pages at the end of the six-page form. Those
18 of you who have used them have probably gotten a computer
19 headache by going through, if you don't download those
20 onto paper.

21 There are some electronic datasets but they do
22 not pick up most of the elements that you would need to do
23 financial hospital analysis. For instance, the NCCS, the
24 Urban Institute collects these pieces of a 990 on a gig

1 core dataset. If you look at the balance sheet items they
2 pick up, the only one they pick up is total assets. So
3 you don't have any breakdown of anything that would be
4 useful to you for doing any of those capital asset ratios
5 or understanding investment categories.

6 And I guess the last part that's really critical
7 to understand is the issue of affiliated organizations.
8 The 990 and the Medicare Cost Reports and the audits and
9 have this problem, except that it's easiest to figure out
10 from an audit whose reporting and what that means, in
11 terms of what you're seeing and what you're not seeing.

12 So the next chart shows you, all these entities
13 are in one stage but it's a multi-hospital system and it's
14 in 2002. What you see is a parent company, a system A, a
15 corporation B, a major teaching system, and then seven
16 more affiliates.

17 The Medicare Cost Report pulls out all the
18 yellow boxes here, the hospital, two physician practice
19 companies, and a real-estate company. The Schedule G on
20 the Medicare Cost Report reports on all those entities.

21 The 990 reports on just the entity that's
22 outlined in pink, which is just the major teaching
23 hospital.

24 And the audited financial statements give you a

1 consolidated view of all of these entities as well as
2 consolidating breakdowns on each one. So when you want to
3 look at financial status, it might help to know what the
4 hospital is embedded in, how the hospital is doing on its
5 own, and then how it's doing in the context of its larger
6 organizational affiliations.

7 And the next slide gives you some sense of what
8 that means. I did do the ratios off the audit. On the
9 pink column the hospital only, the yellow column the
10 single system with the Medicare Cost Reports picking up,
11 and then the green column the consolidated health system.
12 And what you see for our ratios, our capital access
13 ratios, is that the hospital is actually doing quite well,
14 a 3.2 percent operating margin, 6 percent total margin,
15 collecting receivables fine, 195 days cash on hand, almost
16 five times debt service coverage, six-year-old plant,
17 pretty darned good.

18 The single hospital system does less well.
19 particularly on the operating margin, a little less cash.

20 But the consolidated system, when you throw in
21 all of the entities, all the companies, all the different
22 affiliations, the system as a whole only a .2 percent
23 operating margin and a 2 percent total margin. And there
24 I am happy to agree that these guys don't look good. And

1 I wouldn't classify the consolidated as a sustainable
2 margin over all. Although they still have pretty decent
3 cash on hand and average age of plant.

4 In general when you see these complex
5 organizations, if you have a healthy hospital, it is not
6 uncommon for that hospital to be what we call from my MBA
7 days the cash cow for the system where the cash is leaving
8 the hospital and supporting all of these different
9 entities in varies ways, some of which are quite strategic
10 and some of which I don't understand fully but perhaps
11 someone else can figure that out.

12 DR. ROWE: I think the reason it's not easily
13 understood is because you can't understand it from these
14 numbers because there are missions beyond the bottom line,
15 the community mission or the educational mission, which
16 drive a lot of those other investments so that they may
17 not look good from this point of view but it's still
18 important to the institution or the board.

19 DR. KANE: And I think one of the things that
20 you as a group may want to talk about at some point is
21 when you're thinking about how effective is a third-party
22 payment system, which mission are you trying to cover
23 financially? And that's something I guess you all can
24 work on in your spare time.

1 Another affiliate model that's actually a
2 problem, from both the audit perspective and the 990
3 prospective and the Medicare Cost Report perspective, is
4 what I'm going to call the foundation model. That's
5 probably not generalizable, but this is an example of a
6 foundation model in which both the Medicare Cost Report
7 and the 990 are trying to give you information about the
8 hospital entity but there's no balance sheet. It
9 basically has most of the assets in the hospital entity
10 are what is called intercompany receivable or something
11 meaningless. Of this \$177 million in assets, \$105 million
12 is a receivable. So you don't really know anything about
13 plants or debt or any of these. There's no data because
14 the data is all consolidated and the hospital system has
15 not created an audited separate entity statement for any
16 of the other entities.

17 So you have a foundation with \$608 million in
18 assets, \$350 million in investments, \$167 million in tax-
19 exempt debt. But you can't find that from the Medicare
20 Cost Report or the 990 because it's all up there in that
21 foundation. What they say in hospital's 990 is we can't
22 do it. This foundation hospital is related to other
23 organizations, the financial statements are only available
24 on a consolidated basis so we can't give you a balance

1 sheet. They do give you sort of an income statement.

2 And that creates obviously a lot of problems
3 because a lot of hospitals do follow this model where you
4 can't pull it out of the embedded whole.

5 To summarize and maybe add a few more points,
6 there are some benefits and there are some drawbacks to
7 the 990. The good news is all private non-profit hospitals
8 do seem to be reporting on the 990 forms. The bad news is
9 publicly-owned hospitals and investor-owned hospitals do
10 not report a form 990 because they do not fall under the
11 charitable classification.

12 The balance sheet does provide some useful
13 ratios although the bad news is you often have to use the
14 attachments so it's labor intensive. It's not an
15 automated type of exercise.

16 With some changes, which various organizations
17 that monitor these 990s have suggested, the income
18 statement could be made more useful.

19 Also very helpful, when you're looking at an
20 audit, is to have the 990 to give you hospital level
21 detail when you can't get it from the audit. But they're
22 not filed electronically and the hospital entity data is
23 not audited. This is self-reported data and it doesn't
24 always correspond to the audit.

1 If one wants to do a large national sample of
2 990 data and to tell you what's going on with the hospital
3 industry nationally, it requires an analyst to spend a lot
4 of time because you don't have footnotes, you don't have
5 the right classifications of revenues or assets, there's
6 no cash flow statement which is one of the key measures I
7 use for understanding financial health, and the
8 attachments are not uniformly provided.

9 So again, six pages of forms, 40 pages of
10 attachments. An analyst would need a lot of time. I've
11 timed myself a couple times. It takes anywhere from one-
12 and-a-half to two days to do five years off a 990, to get
13 them standardized in any way that you think you have some
14 idea of what's going on, although you still don't know for
15 the income statement what's operating and what's not
16 operating, what's restricted and unrestricted.

17 And you cannot do any of this as a clerk. You
18 have to have a financial accounting background. You need
19 somebody who's fairly well trained to do it.

20 DR. MILLER: That was two days for one entity,
21 right?

22 DR. KANE: One entity, yes. That was me.

23 DR. ROWE: And that was you.

24 DR. KANE: Which means when my husband does it

1 it's three days.

2 [Laughter.]

3 DR. KANE: Findings, the 990s are a useful
4 alternative to the Medicare Cost Report when audited
5 financial statements are not available at the hospital
6 entity level. It's very helpful as a supplement but it
7 does require a lot of analytic effort and training.

8 The Medicare Cost Report is in electronic form,
9 which is helpful, if they could make Schedule G a better
10 schedule. And I think the staff will be talking about
11 that later.

12 And regardless of reporting source, there really
13 needs to be some kind of effort to decide what entities
14 are you interested in. I think you should be interested
15 in both the hospital and the whole and be concerned about
16 what's going on across the hospital and it's whole and
17 what kind of financial implications the whole has.

18 But the reporting for that has not really
19 followed that. So for public policy purposes it is quite
20 hard to get a complete picture of the hospital's financial
21 condition.

22 I think at that point I should stop. Any more
23 questions?

24 MR. MULLER: Thank you for that very useful

1 presentation, Nancy, again.

2 I think, as you said right from the start in
3 your first slide, the report was created for another
4 purpose. And when you have a report created for another
5 purpose it's very hard then to meet other objectives with
6 it. So I think in many ways it's somewhat dispositive of
7 how one can use this. I look forward to obviously your
8 comments, and the staff, on how to better use the cost
9 report.

10 But I think your summary pretty much started
11 from the first slide, which said this is not what it was
12 created for.

13 Thank you.

14 MR. HACKBARTH: Other questions, comments?

15 DR. WOLTER: Is there interest or is anybody
16 looking, other than ourselves, at the 990 and suggesting
17 that it be changed so that it would be more useful? Is
18 the IRS looking at this at all?

19 DR. KANE: I think the IRS is not looking at it
20 as a tool of financial analysis. Again, they're going
21 back to their purposes. The Urban Institute's National
22 Center for Charitable statistics, NCCS, is looking at the
23 990. I just read something that was about five pages of
24 suggestions, some of which would make it more useful.

1 They do pick up on the restricted/unrestricted problems.

2 They do pick up on the consolidation problems.

3 But again they are very much focused on the
4 charitable issues. They really want more disclosure on
5 compensation and loans to insiders. So they're never
6 going to get, because they're looking at such a wide range
7 of organizations, they're never probably going to get to
8 the level that you need to get with a hospital, which is a
9 huge entity. They're looking at these little tiny
10 organizations, many of them, compared to hospitals.

11 So I don't see that upgrading to the level that
12 someone whose organization is totally focused on a
13 hospital would get to, like the Schedule G would be
14 focused on hospitals, could put in requirements around the
15 way hospitals report data and be consonant with the audit
16 requirements. I don't think the 990 will ever achieve
17 that level of compliance or disclosure.

18 DR. REISCHAUER: Nancy, I thought that was a
19 summary of where we are and where we can't go. The fact
20 of the matter is that there's no way on god's green earth
21 that the IRS is going to move in a direction that would
22 make this useful for what we want because its mission is
23 different and is limited to that mission.

24 There will be electronic filing of the 990s

1 slowly taking place. So as Nancy says, it will be easier
2 to get the stuff off the basic form. But much of what you
3 want is in the appendices so it's not clear at all. And
4 that won't be electronically useful, I don't think. And
5 to the extent that we, at the Urban Institute, do delve
6 into this area it really is to examine the evolution of
7 the non-profit sector broadly defined.

8 So I don't think there's a lot of hope in that
9 direction either.

10 MR. HACKBARTH: Any others?

11 Scheduled next is the staff presentation and I
12 think the general drift of the conversation here is that
13 the 990, per se, probably is not the tool to depend on. I
14 think Nancy mentioned, at least in passing, that another
15 direction to go is the Schedule G in the existing cost
16 report and improving that in certain ways. I think
17 that's, in part, what the staff are going to discuss with
18 us.

19 So I'd like to have that. I hope, Nancy, you
20 can stay and the ensuing conversation may come back to
21 some of issues that you've raised in your presentation.

22 Before you go, could I just ask you a broader
23 question? Obviously we, in MedPAC, have focused not on
24 the total overall margin for providers. It's been our

1 policy to look specifically at the Medicare margin for
2 hospitals base our recommendations on that.

3 These Congressional requests are, of course,
4 requests we need to meet but they are sort of a different
5 thrust looking at the overall financial performance of
6 hospitals.

7 Looking however at the Medicare-only financial
8 status of hospitals, what we have seen recently is
9 declining Medicare margins for hospitals. And when we do
10 that calculation, incidentally, we look not just at the
11 inpatient but also if the hospital has outpatient
12 department, home health, SNF. We look at all of them
13 aggregated.

14 And when we get back in the fall to looking at
15 Medicare financial performance of hospitals and moving
16 towards an update recommendation again frankly, I'm a
17 little concerned about what we're going to find given the
18 recent trend of significantly declining Medicare margins.

19 You're looking at the hospital sector from a
20 very different vantage point, looking more at the overall
21 financial performance of hospitals. I'd be interested
22 just in hearing your impressions of what's happening, the
23 financial status of hospitals overall based on the work
24 that you do?

1 DR. KANE: Well, as you know, I don't have a
2 national sample. I do look at different states, often the
3 whole state, but they're not representative. And I do
4 look at some of the indices that are in the public domain
5 such as the hospital almanac and some of the data that's
6 out there.

7 And I think hospitals, which you see often is a
8 peak going up to around 1997 and then they start to come
9 down to around 2000, and then they start to move back up
10 again. That really goes along with perhaps it's the
11 third-party payment system paying better as the premiums
12 have been allowed to rise.

13 But that's very general. There are big winners
14 and there are big losers still out there. So as an
15 industry it's got a huge range in performance.

16 So I think generalizing about the industry is
17 very hard. Some of the bigger, wealthier, competitively
18 advantaged organizations are doing very well, particularly
19 if they have basically a monopoly stranglehold on a
20 market. Whereas some of the smaller hospitals, maybe
21 number two or three or four in the marketplace, don't do
22 so well, often again related to the negotiation process in
23 the private sector.

24 So Medicare is not the only driver, obviously.

1 So I think it's very hard to generalize. I'd say they're
2 doing better as a whole because of the pulling away of
3 some of the constraints on the private sector.

4 MR. HACKBARTH: Why don't we proceed then to the
5 staff presentation? Craig, are you leading the way on
6 that?

7 MR. LISK: David's actually going to introduce
8 this.

9 MR. GLASS: Nancy's going to stay right here.
10 Good morning. This one is the second of the two
11 reports Craig referred to. We call it the data needs
12 report is the short title for this.

13 In Section 735 of the MMA, Congress required
14 that MedPAC report, as the slide shows, on sources of
15 current data to determine solvency and financial
16 circumstances of Medicare providers. Not just hospitals,
17 other Medicare providers as well. And although we're
18 talking about Medicare providers, as Glenn pointed out,
19 this is talking about total financial performance and it's
20 all payers and all costs. It shouldn't be confused with
21 what we generally look at, which is financial performance
22 under Medicare, whether Medicare payments cover the cost
23 of an efficient provider.

24 So this is looking at a different question and

1 this is what Congress wanted us to look at.

2 Nancy Kane's discussion just reflected the
3 benefits and costs of using the IRS form 990 as a possible
4 source of data and we're now going to discuss some other
5 sources of data and some measures you might want to use of
6 financial performance that might be useful for assessing
7 financial circumstances, as they asked us.

8 Both reports are due June first of this year
9 which is a little over a month.

10 The key questions we're going to talk about in
11 this briefing are first, what measures used as indicators
12 of their profitability and solvency. Jeff's going to talk
13 about that. And then Craig is going to talk about what
14 sources of data can be used to construct the measures and
15 how we can improve our data sources. And then I'll sum up
16 when we get to the end.

17 DR. STENSLAND: To evaluate the total
18 profitability and solvency of providers we've convened two
19 expert panels. The first was a panel of analysts from
20 government. The second was a panel of private sector and
21 academic experts in financial analysis.

22 The two panels thought that a provider's total
23 profit margin is a useful indicator of total financial
24 performance. But as Nancy Kane discussed earlier, the

1 total margins can be dominated by non-operating losses
2 such as investment gains. And so to avoid this problem
3 some analysts focus on operating margins. However, our
4 panel believes that operating margins can be inconsistent
5 due to the inconsistency in distinguishing between
6 operating and non-operating expenses.

7 Due to this inconsistency of reporting the
8 operating margins, the panel suggested focusing on total
9 margins in conjunction with the cash flow measure when
10 calculating margins for a large number of providers. Both
11 the total margin and a cash flow measure, such as free
12 cash flow from operations, reflect the return to the
13 owners of the health care facility.

14 The panel also discussed looking at the total
15 return to all investors in the facility. So if we wanted
16 to look at the investment return to both stockholders and
17 bondholders, we may look at the return on investment which
18 is the average return to those two types of investors and
19 is an indicator of the overall attractiveness of the
20 industry to private investors.

21 So far on the first slide I talk a little bit
22 about profitability. Now if we switch to looking at
23 solvency, some panels suggested we examine a cash flow
24 measure called EBITDAR, which is earnings before interest,

1 taxes, depreciation, amortization and rent. A provider
2 might be moving toward bankruptcy when its cash flow as
3 measured by EBITDAR is lowered than its required debt
4 service payments.

5 However, I want to stress that bankruptcy does
6 not always lead to closure. For example, as we remember
7 from a few years ago, a large number of SNFs filed
8 bankruptcy. Following that they restructured their debt
9 and they continued to service patients.

10 While providers with a low but positive EBITDAR
11 may be able to restructure their debts, it will be very
12 difficult for a provider with negative EBITDAR to
13 restructure its debts. These providers with negative
14 EBITDAR are not generating cash flow that can be used to
15 pay their interest and rent expenses. So these negative
16 EBITDAR providers, we expect them to move toward closure
17 unless they can obtain transfers from related entities.

18 The transfers may come from related entities
19 such as foundations or parent corporations. As Nancy Kane
20 discussed, these transfers are often not reported on the
21 income statement. And they are not included when
22 computing the profit margins.

23 They are reported on the statement of changes in
24 net assets. Therefore, when evaluating solvency it's

1 important to examine both the changes in net assets and to
2 calculate a cash flow measure such as EBITDAR using a cash
3 flow statement.

4 So far I've talked about measures of
5 profitability and we discussed measures of cash flow
6 relative to debt service requirements. But when
7 evaluating solvency, analysts also calculate days cash on
8 hand which is a measure of the size of the provider's cash
9 reserves. In addition, analysts often examine financial
10 leverage on the balance sheet using measures such as the
11 debt-to-asset ratio.

12 To calculate the measures of profitability and
13 solvency discussed above, analysts would need to obtain
14 the following four standard types of financial statements:
15 an income statement, a cash flow statement, changes in net
16 asset and a balance sheet. Now Craig can discuss with you
17 how we can obtain this information in a timely and
18 accurate fashion.

19 MR. LISK: We will now review five possible
20 sources of data to create the measures that Jeff and Nancy
21 described.

22 We've already discussed the IRS form 990 so I
23 won't go into that because we've discuss the pros and cons
24 of use of that form.

1 Audited financial statements are another source
2 of data that Nancy discussed and they are prepared by
3 independent auditing firms according to generally accepted
4 accounting principles. They include all the forms that
5 Jeff just mentioned and are available for providers with
6 publicly traded bonds and for providers in some states
7 where states require the filing of these, at least for
8 hospitals and some other providers.

9 They are, however, not compiled on an organized
10 and consistent database that may reflect the consolidated
11 entity and they may reflect the consolidated entity and
12 not the specific provider, although again from looking at
13 those forms you can potentially get a lot of the
14 information on the individual providers within the
15 statements.

16 SEC form 10-Ks are a type of audited financial
17 statement filed with the SEC by publicly traded for-profit
18 corporations. They reflect the corporate entity and not
19 the individual provider. Thus SEC 10-Ks are filed for,
20 let's say HCR Manor Care Nursing Home, Gentiva
21 Corporations but not the individual hospital, SNF, home
22 health agency or dialysis facility.

23 Surveys are another source of data that can be
24 used. The AHA annual survey provides data on the

1 hospitals but is no more timely than the Medicare Cost
2 Reports. It does contain some other type of information
3 on total performance but some of that information is not
4 publicly available. It's only available to the AHA
5 members.

6 The NHIS, National Hospital Indicator Survey, is
7 something that we have used that provides quarterly data
8 on hospitals' total financial performance in terms of
9 limited data in terms of total revenues and total
10 expenses. But only for a sample of hospitals, not for
11 other providers. And it can't be used for judging
12 performance of an individual provider. It's only for the
13 industry as a whole. Medicare Cost Reports is what we
14 come down to next, which cover all Medicare providers of
15 services. It's an electronic database. It includes not
16 just data on Medicare cost and payments but the schedule
17 G, as we've talked about. And all providers who file cost
18 reports have this Schedule G. Now, it may not be
19 identified as Schedule G for home health, for instance,
20 but they do file a similar thing to what hospital's file
21 what's called Schedule G. So we're going to refer it as
22 Schedule G here.

23 So this contains data on a provider's total all
24 payer operations.

1 Since the cost reports are one source of data
2 filed by all providers and available electronically, it's
3 worth spending a little time discussing some of the data
4 issues on the cost reports and in particular Schedule G.
5 These include the timeliness and accuracy of the
6 information included, the consistency in the reporting
7 entity that's included on the provider, and the
8 completeness of the data. In other words, do the cost
9 reports contain all the information needed to conduct a
10 thorough financial analysis. Nancy Kane has covered
11 a lot of that issue in her discussion, as well.

12 Let's move to timeliness. This chart shows the
13 most common cost reporting periods for hospitals. This
14 coming October fiscal year 2003 data should be available
15 for most providers. It's important to understand some of
16 the facts about the timing of Medicare Cost Report data.

17 Cost reports, at their earliest, are available
18 seven to eight months after the end of a provider's fiscal
19 year. Providers have five months to complete the cost
20 reports and then electronically submit them to the fiscal
21 intermediaries. Then the fiscal intermediaries have 30
22 days to approve those cost reports, make sure they have
23 completed them properly, and then another 30 days to put
24 the approved cost reports into the data system for

1 transmission to CMS.

2 CMS then has access to the data within 24 hours
3 at that point in time. This is the data that is used for
4 making the cost report files the analysts use for
5 analysis.

6 Now CMS can produce special runs so the data can
7 be available more timely after this point in time. But
8 generally, in terms of the general community, CMS produces
9 quarterly cost report files that are available about 45
10 days after the close of the quarter. But data can be
11 available a little bit more timely if special requests are
12 made.

13 So what are the prospects of having 2004 data,
14 let's say in the fall? Well providers that begin their
15 fiscal year in July, the top line, they still have two
16 months to file their cost report with a fiscal
17 intermediary at that point in time. For providers who
18 file their cost report periods beginning in October, their
19 fiscal year just ended so there's not likely going to be
20 any data for them in terms of speeding up the process.
21 And for providers who file their cost reports in January,
22 they are still in their fiscal year.

23 So in terms of the timing, that's one of the
24 problems in terms of length of the fiscal year and the

1 length of the reporting.

2 The first cost report data containing
3 substantial 2004 data, in terms of for the people who
4 report who have July's fiscal year start dates, would
5 generally not be available until March of 2005.

6 I next want to talk about the accuracy of the
7 cost report data and there are two issues consider here.
8 First I'm going to talk about the auditing and cost
9 allocation. Only a small proportion of providers' cost
10 reports are audited. While there is a statutory
11 requirement that dialysis facilities be audited at least
12 every three years, there is no audit requirement for other
13 facilities. On average, about 15 percent of providers
14 receive some form of audit every year.

15 The audits are also focused on items that affect
16 payment or I should say basically only focused on items
17 that affect payment. For hospitals, audits may focus on
18 DSH and IME adjustments, the direct GME payments, Medicare
19 bad debts and cost-reimbursed items like organ acquisition
20 costs. For SNFs, audits usually focus on Medicare bad
21 debt payments unless the audit picks up something else
22 that they want to look at.

23 Items on Schedule G for the cost reports are
24 generally not audited since they do not affect payment,

1 although some FIs may do some checking in the desk review
2 process to see if Schedule G information ties to audited
3 financial statements, there is no requirement that the FIs
4 do so.

5 Now one interesting aspect in our look here is
6 hospitals and other providers are required to submit with
7 their cost reports a form 339 which is a survey
8 information that's filed with the cost reports. And with
9 that they are required to include a copy of their audited
10 financial statements to providers to the FIs.

11 These audited financial statements, though, are
12 not subject to FOIA requirements so they are not publicly
13 available but they are used by the intermediaries for
14 doing some checking if they find issues with the cost
15 reports.

16 Hospitals and other providers that don't have
17 audited financials for the specific provider still have to
18 submit financial reports that are used to compile what
19 might be the audited financial for the corporate entity
20 because they still have those pieces that go there. So
21 there is that information that is filed that I thought was
22 important for you to understand that it is filed actually
23 with the cost reports.

24 Cost allocation issues primarily affect the

1 accuracy of cost estimates by department, inpatient versus
2 outpatient for instance, or between payers, Medicare
3 versus private payers. It does not affect the data used
4 to examine total all-payer financial picture of the
5 provider.

6 Cost allocation is an important issue for the
7 Commission and accurately measuring Medicare cost and is
8 the focus of another study that we are in the process of
9 conducting, particularly for this sector costs for
10 inpatient versus outpatient for instance.

11 Next there is no consistency in what providers
12 report as a reporting entity on Schedule G of the cost
13 report. It could be a system with affiliates, such as a
14 hospital-owned physician practice and real estate company
15 that Nancy had showed you. It could be just the core
16 provider. There is no consistency in what is actually
17 reported here.

18 So when we're looking at particular hospitals,
19 we are comparing potential apples to oranges. We're not
20 consistent here in what is gathered.

21 As Nancy Kane just reported to you, how the
22 entity is defined can have substantial impact on
23 providers' financial circumstances.

24 Finally, as Jeff mentioned, some of the base

1 information required to develop some of the financial
2 ratios Jeff and Nancy discussed are not available on
3 Schedule G of the cost report, particularly the lack of a
4 cash flow statement, from our panel, was considered a
5 major shortcoming of the Schedule G of the cost reports.

6 Finally, I want to discuss the options for
7 overcoming some of the limitations on Schedule G of the
8 cost reports. To increase the timeliness of the data you
9 could supplement with survey data, something similar to
10 the National Hospital Indicator Survey, which has some of
11 its own shortcomings but have similar surveys for other
12 types of providers. Such survey data could provide more
13 timely data on cost and revenue trends for a particular
14 sector but cannot be used to judge what might be happening
15 for an individual provider.

16 Alternatively, you could require providers to
17 submit quarterly data on financial circumstances,
18 something similar to the NHIS, but just as a requirement
19 for Medicare reimbursement, for instance, data similar to
20 what's reported on NHIS.

21 Another option is you could require providers to
22 file a Schedule G separate from the cost reports, breaking
23 it off from the cost reports because it's a separate
24 document in some sense but it's not what the basis of the

1 Medicare cost determinations are. And it could be
2 separated. And our panel thought that was actually a good
3 idea.

4 And it could be filed about at the same time
5 that audited financials are required to be filed, about
6 three months after the reporting period.

7 To improve the accuracy of the data, you could
8 require random audits of providers on Schedule G data.
9 Audits, though, could be expensive depending on the number
10 and extent of the audits.

11 One of the issues you have in terms of the
12 accuracy is providers don't have an incentive to
13 necessarily report this data accurately since there is no
14 checking.

15 So alternatively, you could have the FIs just do
16 a check at the desk audit process for checking with
17 consistent with the audited financials. And if providers
18 realized that was happening, they may be more careful in
19 what they're doing on Schedule G.

20 The reporting entity, including the Schedule G,
21 is not consistent across providers and our panel thought
22 it would be most useful to have Schedule G reflect data
23 for basically the smallest corporate entity that contains
24 a provider. This allows for a more apples-to-apples

1 comparisons and gets the core facility's financial
2 performance in terms of how, for instance, hospitals or
3 SNFs are doing on their core business rather than what
4 other things are happening with the other related
5 entities, for instance.

6 But our expert panel also thought it was
7 important to have what's happening with the broader
8 organization, as well. So the consolidated reporting
9 would also be important.

10 So at a minimum, a complete transaction report
11 would be helpful to have in terms of transactions between
12 organizations and the affiliated organizations related to
13 the hospital and other providers or a consolidated
14 financial statement. So essentially, two Schedule Gs in
15 other words.

16 Finally, Schedule G as completed in particular
17 does not include a cash flow statement. Our panel of
18 experts thought that the additional of a cash flow
19 statement would make Schedule G and the cost reports much
20 more useful. And finally, it would be helpful though to
21 have Schedule G also revised to use a standard financial
22 statement form and to conform to GAAP accounting
23 standards. It currently does not. And standardize
24 revenue categories such as operating and non-operating

1 revenue, which are not currently available.

2 So what that, I'll turn it over to David.

3 MR. GLASS: I will just sum it up.

4 Basically, what we are saying is in summary, if
5 Congress wants to understand the total financial
6 performance of Medicare providers, the most direct route
7 is probably refining Schedule G to report clearly defined
8 complete financial information aligned with audited
9 financials. And you could also report it separately so
10 you could get it a little earlier.

11 As Ralph talked about in the last discussion,
12 Schedule G was designed a long time ago and probably for a
13 different purpose and it has some funny things on it like
14 vending machine revenue and that sort of thing. It really
15 hasn't caught up with the current state-of-the-art or
16 generally accepted accounting principles. So it's kind of
17 due for a redesign.

18 This would give us the data to compute, or give
19 Congress the data to compute the multiple measures
20 necessary to assess financial circumstances. These are
21 the measures that Jeff talked about. So Congress would
22 then want to compute those multiple measures, look at
23 total margins, look at cash flow, look at changes in net
24 assets. That would enable us to evaluate profitability

1 and solvency.

2 And finally, we would want to look at trends
3 over time so we can see what direction the industry is
4 going in and to compute some of these measures as
5 meaningful averages. For example, capital costs and
6 investment performance. That might have a lot of year-to-
7 year fluctuations so you'd want to look at it over several
8 years. So if there are any questions or comments on the
9 general organization or tenor of the report, we'd be happy
10 to hear those.

11 DR. ROWE: For me, I think the question is if we
12 had had these data before, and this updated Schedule G as
13 you propose, looking back over the last four to five years
14 can we identify things we would have done differently?
15 Have we make mistakes because of the gaps and the lack of
16 specificity in the information that would have really made
17 a difference because changes like this are not simple and
18 they take a while to do, et cetera, et cetera.

19 So are there specific years that we could say
20 gee, you know, if we had realized this was happening in
21 the hospital sooner we would have not done what we did or
22 we would have done something differently? I think for
23 Congress or somebody, that would be a question that I
24 think would be useful to point to if there are such

1 instances.

2 MR. HACKBARTH: This is where the difference
3 between the question that Congress has asked and the one
4 that we have focused on becomes a bit confusing and
5 disorienting. For reasons that I've discussed ad nauseam,
6 I believe that when making Medicare payment decisions the
7 right thing to look at is the Medicare margin.

8 I don't see that as something you do by default
9 because we don't have accurate total margin information.
10 I think that's the right thing to do as a matter of
11 principle. Now having said that, there are still lots
12 of issues around timeliness of the information and the
13 difficulty of making projections and the like.

14 DR. ROWE: [off microphone.] In the policy this
15 could not be important. That's my question. Would we
16 have done anything different?

17 MR. HACKBARTH: Having said what I just said,
18 Congress did ask for how to best get information on total
19 margins and we're trying to answer that request.

20 So I don't think there's anything we would have
21 done differently. Now whether they would've done anything
22 differently, that's a question for Congress to answer.

23 DR. NEWHOUSE: I agree with this general route
24 of bulking up Schedule G. I think, Jack, although I agree

1 that it would be helpful to cite instances where things
2 might have been done differently, that would be presumably
3 pretty speculative.

4 I think there's a kind of legitimacy or face
5 validity problem to just making policy with data that are
6 a couple of years old, that just on the face of it it's
7 better to have -- I think in the grand scheme of things
8 this seems like reasonably small potato kinds of changes
9 to me, that we're talking about.

10 I have a couple of suggestions. As I understood
11 it, Craig, this is in respect to the timeliness. Without
12 going to quarterly data, which I actually don't favor
13 because I think there's more noise there because of where
14 you recognize revenue expenses and so forth.

15 MR. LISK: That's a good point.

16 DR. NEWHOUSE: I think it's possible to
17 analytically look at each quarter's cohort or month cohort
18 if you want to go that far. So for example, the hospitals
19 whose fiscal year end date is the calendar year, you
20 analyze them. You analyze then the next quarter's cohort.
21 You can do an analysis each quarter if you chose to. You
22 don't have to. You can develop both a weighting factor to
23 say how each quarter's cohort brings you up to the full
24 sample or the universe. And you can, in principle, if you

1 want to go back and develop an estimate of the universe,
2 you could put together a kind of weighted average over the
3 quarters where the weights declined as you went further
4 back in time, reflecting the fact that those were more
5 uncertain estimates as a predictor of the future. So
6 that's one suggestion.

7 And the other suggestion is that, and I just
8 wasn't clear on what if anything we were saying here. It
9 may be useful, and I'll bring this up again in the
10 specialty hospital discussion, if we had costs reported
11 both with and without allocations. Because for some
12 purposes one would, I think, want to know the costs of
13 something before any allocated costs. And I don't see
14 that that would be any great burden.

15 MR. LISK: There was at the panel -- I'm trying
16 to remember the name -- it was the direct contribution
17 margin, for instance if you're looking at a specific
18 service, for instance, with how you would treat the
19 allocated costs. The indirect costs would not be included
20 in that margin estimate. So you're seeing whether the
21 service itself is profitable or it's actual variable cost
22 items.

23 DR. NEWHOUSE: Were you planning to include that
24 as a suggestion?

1 MR. LISK: I guess that's a question of what we
2 cover and going back to what we cover in terms of
3 improvements that are for the Medicare data versus the
4 total data. And yes, on the Medicare data we had
5 mentioned that's something -- and I think it's something
6 the Commission might want to discuss about what we could
7 be using ourselves in terms of how we could be looking at
8 the sector margins, for instance, if we're interested in
9 that.

10 DR. NEWHOUSE: I would think both we and the
11 Congress in terms of -- I'm actually thinking of making
12 separate update recommendations. We might want to know
13 costs before allocations.

14 MR. LISK: Sure.

15 DR. NEWHOUSE: And then for particular policy
16 issues like specialty hospitals one may want to know that.

17 MR. LISK: Yes.

18 MR. HACKBARTH: On the first part of it, I'm not
19 sure I totally understand all of the timeliness
20 suggestions that you made.

21 DR. NEWHOUSE: As I heard the presentation, it
22 was kind of wait until all of the hospitals are in for
23 that fiscal year which means that since we're reporting
24 quarter by quarter, for the early reporters we're waiting

1 a long time. We're way back in time for their cost
2 reports.

3 I was saying at a point in time you can either
4 look at just the cohort of the most recent reporters and
5 try to extrapolate from there. Or what would be better
6 would be to go back in time but down weight the further
7 ago reporters because you're more uncertain that their
8 picture further back is a predictor of the future.

9 MR. HACKBARTH: I'm not sure what the solution
10 is our whether in fact there is a solution on the
11 timeliness issue. When I read the draft text, I was a
12 little concerned that it read in a way that sort of
13 downplayed the timeliness problem. It says one of the
14 limitations in using cost report data is timeliness. On
15 average cost report data are about one year in arrears.

16 And I understand what you mean by that, but when
17 in fact we get to trying to make a recommendation for
18 fiscal year 2006, we will be using fiscal year 2003 cost
19 report data.

20 So it feels like a lot bigger difference than
21 one year in arrears.

22 MR. LISK: That's right and that's part of the
23 interpretation. And what you realize is at that point in
24 time that the Commission is working, fiscal year 2004 just

1 ended and the only cost reports really that potentially
2 could be available are those July reporters. But because
3 of the current timing, having five months to file, they
4 haven't even filed their cost reports yet. And there were
5 issues that were raised by our panel in terms of in the
6 past, I think prior to '97, there was actually a three
7 month requirement for filing for the cost reports. They
8 changed it to five.

9 But providers were asking for and granted
10 extensions frequently because they couldn't do it in three
11 months. And our panel really thought that they needed the
12 full five months to compile that information.

13 And there are other pieces of information that
14 they don't necessarily get and won't have complete to
15 having their data absolutely complete at that point in
16 time for the Medicare part of the cost reports.

17 MR. HACKBARTH: The reason I wanted to leap into
18 the queue here is that's an issue that's come up
19 repeatedly within the Commission. Here's a vehicle for us
20 to, if we have any ideas, make the recommendations here.
21 So as we go around and have our discussion, now is the
22 time.

23 DR. REISCHAUER: I'd like to ask a question on
24 this, sort of a modification of what Joe is suggesting.

1 What we should be interested in is the change
2 from one year to the next. And presumably, if you did
3 this quarterly the sample of hospitals that report at the
4 end of July or the end of June fiscal year is the same
5 from year-to-year. And if we look at the changes, in a
6 sense quarter to quarter -- not it's year over year but
7 you're sort of one group here and then the next it's
8 another group.

9 If there were big trends going on, you would be
10 picking them up and it would be, in a sense, equivalent to
11 contemporaneous -- as contemporaneous as you could get.

12 MR. SMITH: I have no reason to think there's
13 any systematic distribution. We'd have to check and make
14 sure.

15 MR. MULLER: That's what I'm saying, we can
16 certainly look at this idea.

17 DR. NEWHOUSE: There are actually some
18 differences in what the hospitals are reporting but
19 they're stable. You can adjust for that.

20 DR. REISCHAUER: And if you weren't looking at
21 levels but percentage of changes...

22 MR. GLASS: So as I understand what you want us
23 to do is check each of these courts, not a sample of them
24 but everyone reporting at the end of that cohort, and do

1 those.

2 MS. ROSENBLATT: It was my turn. I'm going to
3 jump into this because I come down much harder. As
4 somebody that spends most of my work life working on
5 financials for the health plan industry, quarterly filings
6 to the SEC, I just don't get this. This makes no sense to
7 me.

8 Medicare is spending what, \$400 billion a year
9 on hospital payments or something like this? I would
10 require quarterly data submission. I would require it
11 within 45 days of the end of the quarter. I would tie
12 reimbursement to it. You don't submit within 45 days, you
13 don't get paid. Or late charges or whatever. But I agree
14 with David. Changes are long overdue. This is insanity.

15 And I agree with a lot of your what I would call
16 lower-level recommendations. I would add the cash flow.
17 I would add standard formats. I would add consolidation
18 rules. I would require conformity with GAAP. I would
19 create standards for what is operating and what is non-
20 operating. And I would just try to totally reform these
21 things and get to financial soundness.

22 As a country, we are focused right now on
23 financial soundness. We have, for the last two years,
24 seen scandal after scandal. It's time to totally change

1 this thing.

2 [Applause.]

3 DR. ROWE: Let me make a comment relevant to
4 what Alice said. Our company is maybe not as big as
5 Alice's company, but it's a big company.

6 [Laughter.]

7 DR. ROWE: We close our quarter and I certify to
8 the SEC, under oath I think, within 10 working days of the
9 end of the quarter. And we sign those things and certify.
10

11 And so five months, and we need an extension, is
12 just...

13 DR. REISCHAUER: But you guys are big for-profit
14 entities that are doing this anyway for market purposes.
15 What about the 40-bed hospital in Montana?

16 DR. ROWE: Of it's only 40 beds it shouldn't
17 take that long.

18 [Laughter.]

19 MR. MULLER: We might even get paid by that
20 time.

21 DR. ROWE: They should be done in three or four
22 days.

23 DR. STENSLAND: Maybe a question of
24 clarification from Alice of what you're looking for.

1 There's two bits of financial information and it
2 gets confusing sometimes. The one is the information on
3 total financial performance, and that's like the Schedule
4 G information. And these hospitals are generating that
5 already. That's the kind that you're going to see on the
6 SEC form 10-Ks or 10-Qs.

7 But then there's also the cost reporting
8 information which is what we generate the Medicare margins
9 off of. And they aren't doing that on a quarterly basis.
10 So then we would have to require them to do some sort of
11 quarterly cost accounting if we wanted the cost accounting
12 data and a Medicare margin. If we just wanted a total
13 margin, it's much easier because we can just say give us
14 what you already have.

15 MS. ROSENBLATT: But the total margin for SEC is
16 only the for-profits, right? All you have are these 990
17 things that, from Nancy's thing, aren't very good. So you
18 need something like an SEC on a quarterly basis.

19 But I go along with Medicare is paying a lot of
20 money. So I would require quarterly reporting so that
21 Medicare has the tools that it needs to do its monitoring.

22 I would actually require both, but as a stopgap
23 measure at least Medicare, as this is huge payer, should
24 require some kind of reporting on a quarterly basis. And

1 at a minimum within 45 days. Because I agree with Jack.
2 We're doing it a lot sooner than that and it's possible.

3 Even the 40-bed hospital probably has one or two
4 PCs and it can be done.

5 MS. BURKE: I think back to your original
6 question, Glenn, and that is that we have -- at least as
7 long as I've been involved in the discussions here at the
8 Commission, but for years even at the committee level,
9 there has been a hue and cry about how antiquated the date
10 is upon which we make decisions, which is Glenn's point.

11 And that is there is a sense of being unable to
12 be equitable or make wise decisions because we don't have
13 the data in front of us. And each year the staff
14 struggles to try and accomplish what cannot be done
15 because the data is literally not there.

16 I think Alice's point is exactly right, as is
17 Jack's. And that is I think there is an accounting that
18 has to be done finally. And that is that to the extent
19 that we want this system to in fact be fair and be viewed
20 as fair and be viewed as being based on wise decisions, we
21 have to begin to get that data.

22 And a quarterly requirement for the information,
23 in both cases, I think is not an unreasonable thing to
24 request.

1 Now that also recognizes that the systems are
2 antiquated and many of the issues that have existed in the
3 past have been as a result of the government and what it
4 has asked for and how it's asked for it and how it changes
5 its rules along the road.

6 But I think there ought to be an agreed-upon set
7 of minimum criteria. I think the standardization issue is
8 also a critical one, so that we can in fact begin to see
9 this information in a way that is understandable,
10 irrespective of how the organization is organized and can
11 be compared unit to unit.

12 So I have to say I absolutely agree. I think
13 we've gone beyond the point where we can argue going
14 forward that we can begin to answer what are increasingly
15 complicated questions without having this information.

16 And irrespective of the size of the
17 organization, whether it's a home health organization or a
18 SNF or a 40-bed hospital or a 20-bed hospital, we have to
19 expect these people to be accountable. And that data is
20 the only thing that's going to hold them accountable. So
21 I think we have to get there.

22 MR. MULLER: I think all of us, over the years,
23 have expressed a desire for more timely data in terms of
24 making the right policy decisions. I think it's also

1 important to not so quickly go from thinking that the
2 Medicare Cost Report is that easy to file compared to the
3 standard financial statements. Most entities do have
4 their financial statements available on a monthly basis
5 within several weeks. That's different than filing a
6 Medicare Cost Report. So I think Alice's enthusiasm, in
7 one way, I'm sure a lot of entities could file their
8 standard financial reports quite timely. That's different
9 from filing the Medicare Cost Reports and all of the kind
10 of changes that that requires.

11 So I think the theme here of how we revise the
12 Medicare Cost Report is a very important theme for us to
13 be pursuing. And I think the kind of discussion we've had
14 today is in the right direction.

15 But if you just basically want everybody to file
16 the financial report that they file for their own
17 purposes, whether it's hospitals -- most people are
18 talking about hospitals today -- but whether it's hospices
19 or imaging centers and so forth, I think the reality is
20 that people do have financially reports that come out much
21 more timely than five months after a year. I mean, people
22 do file monthly reports.

23 So I think we should decide do we want those
24 kind of reports? Do we want them on a sampling basis, and

1 so forth, compared to filling out the Medicare Cost
2 Report? There's obviously a lot of desire to have
3 standard information that one can compare. And whether
4 one can truly file a Medicare Cost Report within five
5 days after the end of quarter, I think is something I'd
6 like to have the panel speak to, because you, in fact, did
7 talk to experts in the field. That's point one. So I
8 don't think it's an exact comparison, Alice, to say that
9 these providers don't have financial reports. They may
10 not have the Medicare Cost Report available that quickly.

11 A second point, we've had a lot discussion today
12 -- and this may be more appropriately focused to Nancy
13 than to this panel, but I'll throw it to you.

14 We've had a lot of conversation today about how
15 one treats income, especially investment income, in these
16 reports. I'd like to ask a little bit about how we treat
17 costs, because one of the ongoing themes is whether there
18 are costs that are not allowable and to what extent
19 there's a systemic bias in the reporting of costs that
20 understates cost or overstates cost.

21 So whether Nancy or anybody else wants to speak
22 to that, you've given us some of your considerations on
23 how to think about the reporting of income. But I'd like
24 to get a sense from you whether there's any kind of

1 systemic under reporting of costs that also could go back
2 to Jack's question that might have changed how we analyze
3 some of these kind of issues.

4 Maybe I'll ask for some comments on the second
5 question first, about how report costs and how we
6 understand them. And then perhaps if you help us
7 understand the difference between the -- and to go back to
8 the kind of fervor we have for quick reporting -- what's
9 the fastest one really could file a cost report if it were
10 more simplified? That would be my second question.

11 DR. KANE: Medicare Cost Reporting is not my
12 expertise. Years ago I did actually have to do desk
13 audits of cost reports at the state level and I do know
14 they can get pretty byzantine and I think there is some
15 issue when you're trying to allocate costs by payer that
16 there is a lot of issues that create bias one way or the
17 other.

18 I used to teach students how to do that to
19 maximize revenue, just to help them understand the payment
20 system.

21 So there's no question, as you try to take the
22 cost of the whole operating entity and divvy it up,
23 artificially somewhat, into payers or even product lines,
24 there is some biases that get introduced depending on the

1 incentives and who's going to use the data. So there are
2 biases.

3 Now when you're looking at financial statements
4 there's less opportunity to under- or over-report,
5 although where you classified it on the statement there is
6 some opportunity, non-operating versus operating

7 So I would say on a cost report there are issues
8 of bias and I think everybody has known about them for
9 years, in terms of how you allocate them across product
10 lines or payers. But I think in the financial statements
11 it's not as much of a problem.

12 MR. LISK: To the second question, on the
13 timing, in terms of our panel discussion. Some of those
14 who are actually filing cost reports really said that they
15 thought they needed the full five months to have
16 everything that they needed. So of it was information
17 that they needed. That's on the Medicare reporting in
18 terms of the current structure of the cost reports.

19 In terms of other ideas, in terms of reform of
20 the cost reports, in terms of potentially simplifying, you
21 potentially then get issues if you're trying to get more
22 accurate estimates of costs in terms of dealing with cost
23 allocation issues. You potentially make it less accurate
24 when you do some of those simplifications, for instance.

1 So that tends to go the other direction, potentially
2 requiring more time.

3 They did, though, feel that the Schedule G type
4 of information could be reported earlier and separated
5 from the cost reports and thought, in fact, that it
6 probably should be separated. So that type of total
7 financial performance information could be -- and we said
8 one of the options was some sort of mandated correlated
9 report like we have for NHIS or something like that. It
10 could be much more complete, in terms of ideas. We
11 haven't scoped that out. But those are the types of ideas
12 that could be pursued if you wanted to get more timely
13 data.

14 Now more timely data like that, depending upon
15 what information is collected, could get you not
16 necessarily on Medicare but could get you what the current
17 trends are in changes in costs per case or costs per some
18 unit of service, for instance, that we currently just rely
19 on from NHIS, for instance, potentially is some indicator
20 that we sometimes use.

21 But that data has some serious limitations
22 because of the sample size and other things like that. So
23 a broader reporting would potentially be beneficial. We
24 know providers can do it. There is reporting into

1 Databank for some of this information that many states
2 require.

3 MR. MULLER: There's obviously an enormous
4 difference, like a 14 month difference between five months
5 after end of a fiscal year and 10 months after a quarter.
6 So we are talking such different time frames that I'd like
7 to reconcile kind of our fervor for getting it 10 days
8 after a quarter end and then your sense of -- now I
9 understand the difference you're drawing between the
10 Schedule G and the cost report. But that seems to be such
11 an enormous difference in time, 14 months, that it would
12 be useful for us to speak to what can be done on a more
13 timely basis.

14 And if it's Schedule G, we should perhaps make
15 some estimates as to what a reasonable amount of time is
16 to be able to secure that on a sample that's sufficient to
17 be able to make any kind of policy judgments of it.

18 MR. HACKBARTH: We're already overtime
19 substantially and since this is Friday I fear we're
20 getting to the point if we run over time we're going to
21 start losing people for our final segment.

22 I do want to give Nick and Pete the opportunity
23 to come or ask questions, they've been in line for quite a
24 while. But then we're going to have to cut it off and

1 move forward.

2 DR. WOLTER: I would share Alice's enthusiasm
3 for moving ahead. I think it is disconcerting that with
4 the level of expenditure that we don't tighten up
5 reporting.

6 I am still, though, a little bit kicking around
7 whether quarterly makes a lot of sense in this sector.
8 There really are other reasons for it in the publicly
9 traded sector. So that might be one that we need to think
10 through. But certainly an annual reporting that is linked
11 back to audited statements makes it off a lot of sense,
12 and revising Schedule G makes a lot of sense to me.

13 I would hope that would be done along the lines
14 though of looking at the cost report for other areas that
15 might be simplified in addition to just adding new
16 requirements. Because I think that cost report does need
17 a look and it needs some changes.

18 On a more specific issue, I would hope we would
19 look at reporting of both operating and non-operating
20 margins because although there is variability in how
21 organizations put things into the operating side, for
22 example, that is tightening up over time. And I think
23 they tell us each something that is useful. And then
24 maybe over time it becomes more consistent.

1 And as Glenn pointed out, we have kind of gotten
2 into two sets of issues in this conversation. One is
3 Congress's desire to understand overall financial health
4 in the health care sector.

5 The second is what's going to help us? Whether
6 it's quarterly or annual reporting of this data, that
7 still doesn't get us to some of the issues we're facing in
8 terms of how is Medicare covering costs, particularly in
9 the individual sector areas like inpatient versus
10 outpatient. And I think we still have some very
11 significant issues there.

12 I certainly agree with our chapter that overall
13 Medicare margin is something that we should really use as
14 our linchpin.

15 But underneath that, we're still struggling with
16 systems of payment that are different for inpatient and
17 outpatient. And as we do updates, it's very, very hard to
18 know how to update those separately. And I think that
19 then leads to providers having different incentives in
20 those sectors in terms of how they do their business
21 planning.

22 Those issues are not solved by whatever
23 direction we take on this particular data reporting.

24 MR. DeBUSK: Of course, for the last four years

1 I guess I've been most vocal about old data and I totally
2 agree with Alice and Sheila.

3 But you know, the whole cost reporting system
4 came out of a time where we were on a cost-plus basis, the
5 old TEFRA system. Perhaps we should look at it in a
6 different way. Maybe we should take the GAAP system and
7 look at modifying what is needed on the cost report for
8 Medicare to the GAAP system and try to standardize some of
9 this. Because it's everywhere.

10 We need to break the old plate and start over.

11 MR. HACKBARTH: Okay. I know there's more that
12 could be said but I'm afraid we really do need to move on.
13 We've got commissioners that need to catch airplanes. And
14 the next subject, although it's just a plan for work, is
15 equally interesting and controversial, namely the work
16 plan for specialty hospitals, the specialty hospital
17 study.

18 MS. CARTER: The MMA asked us to examine
19 specialty hospitals. And what was defined in the law was
20 for us to look at cardiac, orthopedic and surgery
21 hospitals.

22 The context for this study is the following:
23 specialty hospitals, practically physician-owned
24 hospitals, represent a small but growing share of the

1 hospital industry. GAO reported last year that the number
2 of specialty hospitals had tripled and now number 100.
3 And there were 20 additional ones under development.

4 Another piece of context is the Stark anti-self-
5 referral law. This law prohibits physicians from
6 referring Medicare patients for certain services to
7 facilities in which they have a financial interest.
8 Hospitals are excluded from this ban. The idea being that
9 an individual physician gains very little from the range
10 of services provided by a hospital.

11 Lawmakers may have different views and concerns
12 about specialty hospitals. In the MMA, Congress imposed
13 an 18-month moratorium on excluding new hospitals from the
14 Stark self-referral ban. As a result, hospitals are
15 subject to the ban, effectively freezing the development
16 of specialty hospitals.

17 Congress also requested two studies. HHS was
18 asked to look at referrals and the differences between
19 specialty and community hospitals in the amount of
20 uncompensated care and the quality of care that they
21 provide.

22 We were asked to look at five areas, hospital
23 costs by DRG and to compare physician-owned and community
24 hospitals costs for the different types of specialty

1 hospitals. We were asked to look at patient selection
2 within a broad category such as heart cases and to compare
3 the mix of cases at specialty and community hospitals. We
4 were asked to look at payer mix and the financial impact
5 of specialty hospitals on community hospitals. And
6 finally, we were asked to determine how the inpatient PPS
7 might be refined to better reflect hospital costs.

8 Our report is due in February of next year.

9 In the last several months, we've met with
10 various representatives of specialty and committee
11 hospitals and these are the themes that we've heard.
12 Supporters told us that the development of specialty
13 hospitals is often physician driven. Some physicians want
14 to improve the efficiency of the services and have become
15 frustrated by the barriers they face in making
16 improvements at the hospitals where they practice.

17 Supporters contend that specialty hospitals
18 focus on the types of cases that they do well and that
19 this concentration has many benefits. For example, they
20 have improved facility designs, staff experienced in
21 treating a specific type of patient and standardized care
22 processes that produce services more efficiently. These
23 features also result in quality of care that is comparable
24 or higher than the care provided at other hospitals. And

1 these same features also result in higher patient and
2 physician satisfaction.

3 Some specialty hospitals acknowledge that they
4 do select certain types of patients but contend that this
5 is responsible practice because specialty hospitals have
6 fewer services such as backup capability and consulting
7 physicians on staff. Patients who are likely to need
8 these services are referred elsewhere so that they are not
9 exposed to unnecessary risk by having been admitted to a
10 hospital that cannot handle their complex medical
11 condition.

12 Supporters noted that some specialty hospitals
13 avoid entering small markets where community hospitals are
14 weak. In such situations the community hospital might
15 fail and it would leave the specialty hospital to provide
16 services that they are not ready to take on.

17 This is what the specialty hospital critics told
18 us. They maintain that the development of specialty
19 hospitals is driven by physicians' desire to raise their
20 incomes. To this end they argue that specialty hospitals
21 select profitable DRGs and within those the uncomplicated
22 lower cost of cases, leaving community hospitals to treat
23 the unprofitable patients.

24 Critics also note that specialty hospitals are

1 less likely to offer certain services like emergency room
2 and uncompensated care. And because profitable cases were
3 selected and treated at specialty hospitals, community
4 hospitals have diminished financial ability to furnish
5 these services or to afford the kinds of improvements that
6 would make them more like specialty hospitals.

7 This brings us to our study. Our first task is
8 to define a specialty hospital. Based on the mandate
9 language, we will focus our study on physician-owned
10 hospitals. We will examine cardiac, orthopedic and
11 surgical hospitals. We will base our definition on
12 specialty hospitals on the degree of concentration, that
13 is the share of a hospital's discharges in a single
14 clinical area. Though our definition will be based on
15 looking at the distributions of shares across hospitals,
16 it cannot avoid being somewhat arbitrary.

17 For comparison hospital groups, as requested in
18 the mandate, we will compare physician-owned specialty
19 hospitals with all community hospitals in their markets.
20 But because this community hospital group is very
21 heterogeneous, we plan to compare physician-owned
22 hospitals with two other groups of hospitals. First,
23 community hospitals that are equally concentrated but not
24 physician-owned. This will allow us to examine equally

1 concentrated hospitals but different in terms of their
2 ownership.

3 A second group, particularly to examine the
4 impact of specialty hospitals on competitors in their
5 markets, will look at community hospitals in the same
6 market that provide comparable services. These are the
7 hospitals that specialty hospitals most directly compete
8 with.

9 In different analysis, we plan to look at
10 different comparison groups and, for example, in looking
11 at quality of care and maybe competition we might focus on
12 specific types of services within even the specialty
13 hospital range of services.

14 Now Julian will summarize the studies that we
15 have planned.

16 MR. PETTENGILL: As we described in the mailing,
17 we have analyses planned in six areas identified on this
18 slide. In addition to that, we plan to make site visits
19 to several markets where physician-owned specialty
20 hospitals are located. This site visits will give us the
21 opportunity to interview people in the specialty hospitals
22 and in local community hospitals to better understand the
23 motivations and the dynamics of this phenomenon.

24 Now what I'd like to do is briefly walk you

1 through the six analytic areas identified here.

2 Once we have a working definition of a
3 physician-owned specialty hospitals and the comparison
4 groups of community hospitals, we will begin with some
5 descriptive analyses of the characteristics of the
6 specialty hospitals and the markets in which they are
7 located. Hospital characteristics would include things
8 like the number of hospitals, their locations, size,
9 services offered and that sort of thing. We will also
10 have some information on their ownership arrangements and
11 their Medicare and market shares. For the markets we
12 plan to contrast markets with and without specialty
13 hospitals and will be able to assess whether they are
14 rural or urban in character, population characteristics of
15 the people living in the area, and some other features of
16 the market and regulatory environment.

17 The next topic is patient selection. This part
18 of the study will examine differences in DRG case-mix and
19 severity of illness within DRGs between physician-owned
20 specialty hospitals and the community comparison groups.
21 Most of this analysis will focus on Medicare data,
22 Medicare case-mix and illness severity using claims from
23 the 2002 MedPAR file.

24 For a few states we may also examine case-mix

1 and severity differences between specialty and community
2 hospitals for the population covered by private payers.

3 In a third part of the study we will be looking
4 at differences in profitability across DRGs under
5 Medicare's inpatient prospective payment system and we'll
6 also look at whether private payers payment rates appear
7 to follow a similar pattern across DRGs.

8 For the Medicare inpatient prospective payment
9 system we will use data from the claims and the hospital's
10 cost reports to estimate payments costs and profitability
11 across and within DRGs. For the private payers analysis
12 we will be using the pattern of payments per case in
13 private insurance claims and will compare that with the
14 pattern under Medicare.

15 If we find substantial differences in
16 profitability in the PPS we will then examine potential
17 refinements to the DRG definitions and to the way the
18 weights are calculated that might make profitability more
19 uniform across DRGs and thereby reducing payment
20 incentives for favorable selection and specialization.

21 The next part of the study will address the
22 quality of care. And here we'll be looking, to the extent
23 possible, at differences in the quality of care between
24 physician-owned specialty hospitals and our comparison

1 group of our community hospitals. We will use many of the
2 same mortality and patient safety indicators that the
3 Commission used in its quality chapter of the March report
4 this year. Our ability to find quality differences in
5 this analysis will be limited you understand, of course,
6 because we're likely to have relatively few physician-
7 owned specialty hospitals and correspondingly small number
8 of cases to work with here in which we're trying to find
9 relatively rare events. Kind of a bad combination.

10 We will also look at differences in length of
11 stay, transfer rates and discharge disposition of
12 patients.

13 And then, as we were asked to do, we will also
14 examine the effects that specialty hospitals have when
15 they enter the market on beneficiary service use, program
16 spending and, of course, the community hospitals'
17 financial outcomes. Again, our ability to find much here
18 to answer these questions will be limited because most
19 specialty hospitals haven't been around for more than a
20 few years. Consequently, we don't have very much
21 information to work with in terms of cost report data and
22 so forth.

23 We may be able to take a case study kind of
24 approach in a few markets where specialty hospitals have

1 been around for four or five years and we may have to be
2 satisfied with that because there's simply no other data
3 available.

4 Another way to get some sense about some of the
5 potential outcomes, at least regarding substitution across
6 sites of service and impact on program spending, is to
7 look at what's happened with the entry of ASCs into
8 markets. The advantage there is that ASCs have been
9 growing rapidly for a long time. They have been around a
10 lot longer and we have much more data to look at. And of
11 course, they are of interest in their own right. That's
12 the one study that Ariel talked about yesterday. So we'll
13 be doing that.

14 And then finally the last area, we weren't asked
15 specifically to do this, this is something that HHS was
16 asked to do. But it's awful hard to talk about this topic
17 without going into the origins and evolution of the self-
18 referral policy. It's a very important part of the
19 context. It's also one area of policy in which
20 modifications might be made to address the underlying
21 issue of whether specialization of this kind is
22 appropriate and how one might limit it. So we will have
23 an analysis of the origins and evolution of the policy.

24 We will also have some analysis of other

1 strategies that some of the states have been considering.
2 This would include things like requiring all hospitals to
3 have a staffed emergency room and other restrictive
4 policies that sort of raise the barrier to entry.

5 Now we'd be happy to take any questions or
6 comments or suggestions.

7 DR. NEWHOUSE: I have a couple of suggestions.
8 One is in the analysis of cost. It wasn't clear in the
9 draft you circulated but I think you should use costs in
10 the acute care hospital before allocation. That is
11 conceptually you want to know what costs would have been
12 incurred in the acute care hospital but for the care
13 moving out. So you do not want fixed costs in that
14 comparison.

15 And my guess is that the unallocated costs are a
16 better approximation of that than the allocated costs.
17 But you should use your judgment. --

18 MS. CARTER: So you're talking about the
19 allocation of overhead, not the allocation to Medicare?

20 DR. NEWHOUSE: Correct.

21 My second suggestion is on the control group.
22 There was a discussion and, in fact, you alluded to it in
23 your presentation, of using a control group of community
24 hospitals where specialty hospitals are located. I

1 actually think you want two comparison groups. You'd like
2 to look at community hospitals where there's more and
3 where there's fewer specialty hospitals to look at an
4 impact.

5 MR. MULLER: I think you did an excellent job of
6 laying out the study design.

7 Going by analogy back to some of our concerns
8 seven or eight years ago about whether we have the right
9 risk adjustment in the managed care plans and whether
10 there's a lot of opportunities by careful case selection
11 to profit handsomely from the Medicare program. I think
12 we should also look at to what extent the specialty
13 hospitals can undermine the whole PPS system because
14 obviously you get it in some part here.

15 But in a system based on averages the extent to
16 which one can ride below the averages and take off cases
17 that do not -- take cases and aggregate them in a way, as
18 you point out in your analysis, by having this just in
19 three specialties, many of them not having a wider range
20 of services, not having emergency rooms and so forth, a
21 lot of the complexity that goes into a more general
22 setting is obviously not witnessed -- I mean, I shouldn't
23 presume it but it may not be witnessed there. The GAO
24 study showed that as well.

1 So I'd you to consider commenting on the study
2 as to what extent this moment can, in fact, undermine the
3 whole integrity of the PPS system.

4 MS. BURKE: I won't repeat it but I, in fact,
5 was going to make the same point that Ralph was going to
6 make. I do want to understand that sort of fundamental
7 question about whether this really does undermine the
8 whole thought as to how we built the PPS system.

9 But at the risk of repeating yesterday's
10 arguments, I wonder whether there is anything that we will
11 learn here or that we could learn here that would inform
12 us as well on the issues relating to the LTCHs.

13 There are similar kinds of questions about
14 market analysis, about impact on the community hospitals.
15 And I wondered if there isn't, as we look at both of these
16 issues and build an understanding of the markets in the
17 community hospitals and what has happened in terms of
18 service mix, whether there isn't some benefit sort of both
19 sides looking for some of these issues together and
20 perhaps looking to what extent there are similarities or
21 answers that might be gleaned from either study that would
22 help the other.

23 MR. PETTENGILL: I think some of the analysis of
24 DRG profitability and case selection within DRGs and that

1 sort of thing would be very relevant to the long term care
2 hospital problem. By having said that, that's probably
3 the only part where there's sort of a direct parallel.
4 The rest of it, the study population we have to look at
5 here in terms of markets and hospitals, the database in
6 effect, is very different.

7 DR. WOLTER: I think this was very well put
8 together and certainly it's ambitious when you look at
9 looking at DRGs and the self-referral issues and all of
10 these things.

11 I think though, that if we get some good
12 information back that this could be very, very helpful.
13 And as you know, I'm very interested in the DRG
14 profitability issue because I think, even aside from the
15 specialty hospital issue within the not-for-profit
16 hospital sector itself lots of decisions around business
17 strategy get made on that basis which are not always
18 driven by what's in the best interest of the services
19 needed by the beneficiary. So I think that could take us
20 in a number of directions.

21 And then that I would just underscore, I think
22 the whole issue of self-referral is so important and it is
23 a very difficult issue, an emotional issue. We have rules
24 about it in some areas but not in others. But when is it

1 a conflict of interest to be referring to yourself and
2 when is it not? And there are gray areas here. But I
3 think that discussion can be quite valuable.

4 DR. WAKEFIELD: No rush. Go-ahead.

5 MR. DURENBERGER: We're on the same plane, go
6 ahead.

7 DR. WAKEFIELD: You're right, we are on the same
8 plane, it's true. You're not leaving without me, Dave.

9 You mentioned in the text that you provided us
10 that proponents of specialty hospitals suggest that
11 patient satisfaction is perhaps higher for patients
12 treated in those facilities.

13 Is there anything that you could access that
14 would give us a sense from national datasets in comparing
15 these hospitals to non-specialty hospitals about the
16 patient satisfaction? Any read that we could get on that?

17 Because your quality data, as you indicated, are
18 pretty thin in terms of what you're going up to look at.
19 Could you do inpatient satisfaction or is that not going
20 to be an option?

21 MR. PETTENGILL: That's something we'll have to
22 explore. I hadn't considered that. But certainly, if
23 there are data at CMS, but I'm not sure about that. We'll
24 have to talk to Karen and see what we can dig up.

1 MR. DURENBERGER: Of course, since I made that
2 crack about being your mother...

3 DR. WAKEFIELD: People who weren't here
4 yesterday won't understand that.

5 MR. DURENBERGER: Alan, are you Medicare-
6 eligible yet?

7 DR. NELSON: Yes.

8 MR. DURENBERGER: Oh, there's two of us.
9 I have two suggestions. One of them does go to
10 sort of the heart of the study. But the study is really
11 great and it's really terrific.

12 One is sort of like a suggestion about focus.
13 And I think as I look over what the specialty hospitals
14 say about themselves, efficiency, quality, satisfaction,
15 innovation, and things like that, that is the same thing
16 that people care about. And so I just think if the focus
17 of the report, like the very last thing up there, really
18 is on answering the question which is what should
19 communities look like in terms of high quality,
20 innovation, access, choice, a whole variety of things like
21 that.

22 The other issues, which are the complaints from
23 general hospitals, probably are not necessarily the first
24 choice of priorities by the vast majority of citizens,

1 although they are important to some and they do need to be
2 dealt with.

3 But if we focus this not just as one group
4 versus another group and who's right and who's wrong and
5 so forth, but just think about it as a community of people
6 and highlight the things that people ought to be concerned
7 about, which are efficiency, quality, satisfaction,
8 innovation, access, choice and so forth, you can still get
9 to the same issue. But I think the report has more
10 meaning to legislators who asked you for it.

11 The second one is related to that. In the study
12 plan I think the selection of the communities you go to is
13 very important because there are communities in this
14 country that are already starting to deal in some way with
15 this issue not just legislatively.

16 And in that regard, if you would add to the list
17 of people that you talk to purchasers, particularly large
18 employers. And if you can get beyond the sort of level of
19 frustration that they have when they see this competition
20 going on and they know they're paying for it but they
21 don't understand it, try to understand better as you look
22 at various of these communities what role the purchasers
23 believe, on behalf of employees and all that sort of
24 thing, they could or might be able to play in this whole

1 process. I think it would give us some helpful
2 information.

3 And I'm assuming the people at the Center for
4 Studying Health System Change, who I know help us out at
5 various times, can be helpful to you in both regards.

6 MR. HACKBARTH: Anybody else?

7 Okay, thank you very much.

8 So we are now to the public comment period and
9 we will briefly accept comments.

10 With all the usual ground rules, which you
11 should know very well by now.

12 MR. FENNINGER: I do indeed. And I've been told
13 before that if I'm the only one up here I still don't get
14 all the time.

15 Randy Fenninger. I represent the American
16 Surgical Hospital Association, which is the trade
17 organization for about 60 of the 100 or so specialty or
18 surgical hospitals which have been identified. We
19 appreciate the opportunity we have had so far to meet with
20 the staff and are delighted that they will be making a
21 site visit or site visits.

22 I would note that each of you will receive, if
23 you have not yet received, an invitation to visit a
24 hospital as close to your home as we can possibly find to

1 give you the opportunity to see what a specialty hospital
2 is and is not, because they are designed to do certain
3 things and they are not designed to do other things.

4 I think we all know what a community hospital,
5 is either professionally or personally. We hope you will
6 take advantage of the opportunity that will be provided
7 over the coming months to learn more by such a site visit
8 either with some of your staff or independently.

9 I would just add a couple of cautions. I
10 actually think the design of the study, the way it was
11 laid out, is very good, it's very thorough and queues
12 closely to what Congress said.

13 I'm a little bit concerned, having heard this
14 morning's conversation and discussion about measuring
15 revenues and costs and impact, how you're going to compare
16 what may or may not be happening to community hospital
17 revenue and finances, given the difficulties you have
18 already defined in your previous discussions of measuring
19 that exact element. And yet that's quite key, I think, to
20 the overall debate that is going on.

21 So I guess we'll just all have to live with two-
22 year-old data in whatever you find because I don't think
23 you'll fix the one prior to the other.

24 A couple of things. First of all, I would urge

1 all of you to take a very open mind into this debate and
2 discussion. I think you pride yourselves on doing that
3 and I can only encourage you to continue to do that as
4 this goes forward. This has been contentious and
5 emotional, as you will know, in Congress and in
6 communities where these hospitals are under development or
7 have been developed. And good analysis is an extremely
8 short supply. We're very hopeful that we get more good
9 analysis coming out of this particular effort.

10 We would suggest you take a very careful look at
11 why these hospitals grow up. Why are they developed?
12 They are very unique to the community setting in which
13 they occur, whether that's Durango, Colorado; Kalispell,
14 Montana; Modesto, California or some other city,
15 Milwaukee, Wisconsin which I refer to as ground zero of
16 this whole debate.

17 But I think it's important that as you go
18 through your analysis that you understand the rationale in
19 those committees because they are different. And the
20 different kinds of hospitals are different. We represent
21 primarily hospitals that perform elective surgery for
22 patients who are otherwise healthy, be they Medicare or
23 non-Medicare. You will find perhaps cardiovascular
24 hospitals having a somewhat different structure, a

1 different model, a different in the community.

2 So just as you have commented in the past on
3 ASCs, they all don't look alike, they all don't function
4 alike, there are differences. And those will be
5 important, I think, to your consideration. And I urge you
6 to take cognizance of that, as well.

7 As you go through this, it might be interesting
8 as a sidelight to examine some of the tactics that are
9 being used in communities where these hospitals are either
10 consideration or under development. As you do this
11 analysis at the staff level, I cite economic credentialing
12 and exclusive contracting as two issues that you might
13 find interesting.

14 On the timeliness of data, the earlier
15 discussion, I want to volunteer our association and our
16 members to be the first to say you want it in a week,
17 we'll get it to you in a week. What can we do to help?
18 We think we're efficient and we think we could probably
19 provide that information to you far more quickly than it's
20 currently coming out, if that's at all helpful.

21 Let me close by saying it will be difficult I
22 think, and I think your staff has told you this, it is
23 going to be difficult to answer all of the questions with
24 a great deal of depth partly because of data limitations

1 in the Medicare data about our members and the communities
2 in which they operate.

3 We hope you will not use that as a reason for
4 encouraging Congress to extend the moratorium. We know
5 that we are the new kids on the block. We know that much
6 of the data that you will be looking for is not going to
7 be readily available. We don't think that's a reason to
8 continue to aid and abet monopolization by one set of
9 providers in many communities. And we hope you will
10 consider that as you go forward and reach your conclusions
11 for your final report.

12 Thank you.

13 MS. THOMPSON: Hi, I'm Ashley Thompson with the
14 American Heart Association. And I just wanted to commend
15 the commissioners for their discussion on the data needs
16 and the need for more for timely data.

17 Our organization absolutely shares the same
18 desire in this respect, and we've been working with the
19 hospital field in order to provide more timely data
20 through avenues such as NHIS and Databank, which have been
21 listed. And we do know that those have some limitations.

22 What we wanted to share with you is, as you
23 continue this very important discussion, we share Mr.
24 Muller's concerns about jumping thoroughly into using the

1 Medicare Cost Report and requiring a timely or a more
2 timely turnaround of that document as it does contain some
3 data that is difficult to obtain. We just want to look at
4 that more thoroughly.

5 However, the idea of using Schedule G as an
6 avenue to get at more timely information is something that
7 we would like to look at with you. So we do want to offer
8 our help and assistance as you move forward in this area.

9 Thanks.

10 MR. HACKBARTH: Okay, thank you. We're
11 adjourned. [Whereupon, at 12:17 p.m., the meeting was
12 adjourned.]

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