

1 The new thing that seems to be going on, which I
2 think we need to be attentive to going forward, is that a
3 lot of now practices that have an ability both to improve
4 quality and to have market leverage with plans are not
5 getting higher fees. They're getting it in
6 performance-based payments.

7 In other words, they're achieving certain
8 performance goals. They're getting significant additional
9 payments, and that won't show up as a fee schedule
10 differential, but it's actually a payment change. It might
11 not show up in claims at all. This is not a broad, national
12 thing, but I'm finding it's beginning to happen. And going
13 forward, again as you're thinking of methodologic issues to
14 stay on top of this, I would just point that out.

15 MR. HACKBARTH: So let me ask another question
16 since Bob had the microphone. Maybe even Bob is the right
17 person to answer it. So the draft chapter quotes the work
18 that Urban did saying how much would physicians be paid if
19 everybody were paid at the Medicare fee schedule, and my
20 recollection is that the answer was on average 12 percent
21 less than currently. And then we have this number that
22 Medicare pays at 80 percent, 20 percent less. I think I

1 know how you reconcile those two numbers, but it might be
2 good to explain that.

3 DR. BERENSON: Go for it.

4 DR. HAYES: I'll try it and we'll see what
5 happens. So it's a question of comparison, of the type of
6 comparison that's being made. And so in the case of the 80
7 percent number, it's pure Medicare compared to pure, in this
8 case, PPO rates; whereas, with the -- with the simulated
9 versus actual, we're talking about a simulated being pure
10 Medicare, but the actual is a mix of Medicare, private, even
11 Medicaid. Right? And so you end up with a smaller
12 percentage because of that.

13 DR. BERENSON: And there's a marginal difference
14 because the compensation includes some non-professional
15 revenues from, say, drugs and things that are not
16 comparable. So it's not an exact thing, but if you assume
17 that Medicare is about 30 percent of the average physician
18 practice and you do the calculation, they're very similar
19 numbers. The 12 percent pretty much translates into a 20
20 percent differential.

21 MR. HACKBARTH: George?

22 MR. GEORGE MILLER: I want to thank Kate for

1 teeing the question up about disparities. In the material
2 that you sent us, there was a statement that both
3 minorities, dual eligibles, and Medicaid patients are least
4 likely to go to ASCs, and I don't know if you thought about
5 a policy issue, how to deal with this. It seems to be that
6 this issue is growing over time as we have an increased
7 number of ASCs, increased number of procedures, but the
8 number of dual eligibles, minorities, and Medicaid patients
9 seem to be growing or not getting that same service.

10 I don't know if you have a policy issue,
11 particularly in the material that says the Commission
12 recognizes the benefits of the ASC offer, and I would agree
13 with that statement, but I'm a little concerned about that.
14 If those three groups we just mentioned don't have the same
15 access to that benefit, there is a disconnect, or for me,
16 it's an inequitable situation. So from a policy standpoint,
17 how would the Commission recommend we deal with this
18 disparity?

19 MR. WINTER: Yeah, we didn't attempt to lay out
20 sort of policy options. If you all want to discuss that and
21 suggest ideas for us to pursue, that's certainly in your
22 purview. We just laid out the data in response to your

1 request from last year. We did a similar discussion last
2 year in the chapter and were we could we tried to discuss
3 factors that might lead to this kind of disparity.

4 For example, in dual eligibles, it could be that.
5 Medicare beneficiaries are more likely to go to hospitals as
6 a usual source of care, or to the emergency room.
7 Therefore, when they get outpatient surgery, they go to the
8 hospital instead of the ASC.

9 It could also be linked to the decisions about
10 where ASCs tend to locate relative to hospitals. So we try
11 to explore some of the factors in terms of policy
12 alternatives that we don't go that far and we're open to
13 your suggestions.

14 MR. GEORGE MILLER: But is there evidence that
15 minorities or dual eligibles or Medicaid patients seek out
16 the emergency room or seek out hospital versus an ASC? Is
17 there any evidence that that's true?

18 MR. WINTER: They seek out? I don't have evidence
19 about that. There's one study by John Gable published in
20 Health Affairs in 2008 where he looked at referral patterns
21 for physicians who owned ASCs versus other physicians and
22 found that physician owners of ASCs were much more likely to

1 send their Medicare and commercially-insured patients to an
2 ASC than their Medicaid patients, where they're more likely
3 to send them to the hospital. So on the physician side,
4 there's some evidence there. In terms of the patient side,
5 I'm not aware of any evidence, any research.

6 MR. GEORGE MILLER: Okay. Well, that's
7 problematic to me. If that study is true

8 DR. CASTELLANOS: Can I answer that question?

9 MR. GEORGE MILLER: Sure

10 DR. CASTELLANOS: Because you put it up before. I
11 looked at my ASC and now I understand there's only one out
12 of 5,000. But Medicaid in our state, Florida, will not
13 cover any procedure in the ASC, Medicaid.

14 MR. GEORGE MILLER: Okay. That's one of three.
15 You've got minorities, you've got dual eligibles, and they
16 all seem to be, statistically, not being seen at ASCs. I
17 understand the Medicaid issue. If it's a financial issue, I
18 don't have a dog in that hunt. But if an equally qualified
19 minority who has commercial insurance, and according to this
20 statistic, they're not seen as much as in the physician
21 offices or the ASCs, I've got a problem with that.

22 MR. HACKBARTH: It could be issues of location,

1 where the ASCs are located so we can definitely dig into it
2 some more.

3 MR. GEORGE MILLER: I live in the little town of
4 Springfield. I mean, it's not that big. There's three ASCs
5 in that community, including a specialty hospital. You
6 don't have to drive that far.

7 DR. MARK MILLER: We can do some more thinking
8 about this, but to the extent that there was evidence here,
9 if it is a referral pattern issue, exactly what we're going
10 to do in terms of policy, I think, could get -- and I'd be
11 interested in your views if it comes to that point.

12 MR. HACKBARTH: Okay. Continuing with Round 1
13 clarifying questions. Cori and then Mike.

14 MS. UCCELLO: I'm just going to pick up on
15 something that Bob said about access for folks aging in.
16 The ACA could potentially, in a few years, impact access of
17 the 50 to 64 year olds, even just the privately insured. So
18 that could, in turn, have some effects as people age in to
19 Medicare. So it's a few years down the road, but it's
20 something to keep in mind.

21 Clarification for Glenn on the recommendation of 1
22 percent is, in effect, MEI plus 0.3. Right? Did that

1 factor in? I just kind of want to get more understanding of
2 where that came from.

3 MR. HACKBARTH: The 1 percent is not the result of
4 a calculation related to MEI. I think this -- how many
5 years now? It's at least a couple that we've used the 1
6 percent. We've set a modest update, the really salient
7 point being that we don't think 50 SGR cut should go into
8 effect and that a modest update would be appropriate. My
9 recollection is we've used 1 percent now for at least a
10 couple of years.

11 MS. BOCCUTI: Last year we said the 1 percent.
12 Before it calculated to become about that amount.

13 MR. HACKBARTH: Mike?

14 DR. CHERNEW: I just want to make sure I
15 understand the connection between this recommendation and
16 the SGR. So this is essentially a complete override in the
17 sense that it doesn't need to be paid back. So all the
18 other overrides they do when they go to -- say they were to
19 go to 1 percent legislatively, the standard thing would have
20 been to have to pay it off through some other mechanism.

21 When we recommend 1 percent, if we were, they
22 would still have to do that, or explicitly decide not to.

1 They can't just say, okay, 1 percent, now we don't have to
2 pay for it. So they would still have to either decide to
3 pay for this 1 percent versus the SGR baseline or not, as I
4 think the chapter and Cristina said. I just want to be very
5 clear. Our recommendation has nothing to do with paying for
6 or not paying for. So it should be 1 percent.

7 MR. HACKBARTH: So this would, in fact, be added
8 to the tab. We'd say override the gargantuan cut and
9 substitute 1 percent. That means that the unpaid balance of
10 the SGR bill, if you will, goes up by -

11 DR. CHERNEW: So that's automatic. Right. That's
12 what I'm trying to understand. So if they do that, the way
13 the SGR is written, that unpaid tab portion you just
14 described, that's automatically -- if they don't do anything
15 else, that automatically happens.

16 MR. HACKBARTH: Correct me if I'm wrong. So that
17 implies that the next time they calculate a cut to reach the
18 SGR line, it gets yea bigger.

19 DR. CHERNEW: That's what I wanted to know.

20 MR. GEORGE MILLER: But just to follow up on that
21 point, for example, we can make the recommendation of 1
22 percent and Congress, in its wisdom, could come back and

1 say, well, we're going to take that out of home health or
2 hospitals. It would be nice to know that beforehand.

3 DR. CHERNEW: Exactly, but it does affect the SGR
4 hole that we're in. I just want -- because we're going to
5 vote in this recommendation, and I just wanted to know if
6 this vote had ramifications for the SGR hole.

7 MR. HACKBARTH: It increases the hole, yeah. But,
8 George, if Congress can selectively take any of our
9 recommendations and do whatever they want, mix and match,
10 that's just the world in which we live. That's not unique
11 to this. Peter?

12 MR. BUTLER: One quick comment on this warning
13 light idea on access is a good one. I would think about the
14 survey and do it a different way. I would do a random 500
15 secret shopper. Call the doctors' offices you can. I have
16 an appointment. It would be a different way of kind of
17 surveying this to kind of say, I wonder if there really is
18 -- just a little different twist.

19 But my question relates to the MEI, because I've
20 tried to struggle with the true costs of what does it cost
21 this year versus next year to run a physician's office, and
22 obviously I'm thinking of kind of an EMN coded -- different

1 -- one part of the span. So the MEI has gone up 20 percent
2 over ten years and 0.7 in 2012 and it includes a
3 productivity adjustment for the national GDP productivity
4 growth. So just tell me a little bit more about your
5 assessment of the 0.7 and remind me of the components,
6 because you could say, hey, 1 percent, that's more than the
7 costs increase in the practice. You ought to be able to
8 live with that.

9 DR. HAYES: The 0.7 includes a productivity
10 adjustment. Otherwise, it's based on a forecast of changes
11 in input prices for all the different inputs that go into
12 furnishing physician services.

13 MR. BUTLER: And the productivity piece of it is
14 for this year coming up as what of the 0.7? In other words,
15 what would it be without the productivity adjustment,
16 because I think that's the part that -

17 MS. BOCCUTI: 1.3.

18 DR. HAYES: 1.3.

19 MR. BUTLER: That's the part that people have a
20 hard time swallowing, how many more patients can I see a
21 day. It's not easy.

22 MS. BOCCUTI: So it would be 1.3 plus the 0.7, and

1 then when you take the 1.3 out, so that comes to -

2 MR. BUTLER: So it's 2.0 without -

3 MS. BOCCUTTI: 2.0. You take out the productivity
4 adjustment. This is how CMS, the forecasters -- when you
5 take out the productivity, you get an MEI, an adjusted MEI
6 of 0.7.

7 MR. BUTLER: Right. Got you.

8 DR. NAYLOR: So thank you. A couple quick
9 questions. Do we know how increasing access to other
10 providers affects these outcomes? I know you've seen
11 between 2007 and 2009 a growth in the sense that people have
12 access to primary care practices. So of the 140,000 nurse
13 practitioners, or now we have an increasing federally
14 qualified health centers, nurse-managed health centers,
15 community-based health centers, and they are growing. So do
16 we know how increased access to team-based provided or other
17 provider services, primary care services, influence these
18 outcomes?

19 MS. BOCCUTTI: Well, the MCBS asks about a usual
20 source of care, and in that, they include doctors -- I
21 looked at doctor's offices, doctor's clinics, and thinking
22 it's hard to say what the other clinic -- those are the ones

1 that most specifically, I think -- some of that came to --
2 95 percent of beneficiaries said that that was their usual
3 source of care.

4 DR. NAYLOR: I think given the growth, and
5 especially spawned by the Affordable Care Act going forward,
6 including now. I mean, in the last five years, we've seen a
7 rapid growth of other types of primary care, and including
8 and especially in areas that are serving vulnerable
9 populations, et cetera. So I'm interested in knowing, is
10 that -

11 MS. BOCCUTI: Okay. So if we were putting this in
12 a survey, what would be the right way to characterize
13 another -

14 DR. NAYLOR: I think it's a primary care practice.
15 Even at the growth in our state in the last three years in
16 advanced medical or health homes is predicated on having
17 access to nurse care coordinators. So when people are
18 responding, we need to know what they're responding to,
19 because they would say, I have increased access to such-and-
20 such. So I think we're going to have to make sure that the
21 language of these surveys reflects -- and it might be one of
22 the reasons we're seeing, from 2007, a 70 percent sense that

1 I have access grow to 79 percent just because of how people
2 are interpreting it.

3 MR. HACKBARTH: Do you -- go ahead.

4 MS. BOCCUTTI: Would an FQHC -- and Tom, I'm asking
5 you, too. If we ask the question, and we've been thinking
6 about this, this topic specifically, so forgive me for a
7 minute here. If it was an FQHC, would they respond to that
8 as a primary care practice?

9 DR. NAYLOR: They well might. I mean, so you are
10 going to need to -- certainly if it's a nurse-managed health
11 center, which are going to grow, you need now to make sure
12 that you're distinguishing the various options. But I think
13 we do know that they are responding to access as the, I have
14 access to someone who's caring for me.

15 MR. HACKBARTH: Mary, looking at this from the
16 patient side and patient surveys, do you think that the
17 typical Medicare patient understands the term primary care
18 practice and can relate to the way we frame issues? That
19 would be a question for you. Right now we're asking them,
20 as I understand this survey, can you get to access to
21 routine care when you want.

22 MS. BOCCUTTI: And we say doctor. I don't want to

1 dumb it down so that we don't get the right information, but
2 I want to get information that we can translate clearly.
3 And we often say doctor. But I want to be able to bring
4 this in, so I equally want

5 MR. HACKBARTH: Let's flag this as an issue that
6 we can try to work through.

7 DR. NAYLOR: I was going to say the Commonwealth
8 Fund, we've spent a lot of time on their surveys and they
9 have figured out how to do this in a way that helps you to
10 understand. So I think that would be a great starting
11 point.

12 MR. HACKBARTH: Yes, good.

13 DR. NAYLOR: And the last thing quickly is, when
14 you talk about this 1 percent and it says would increase
15 Medicare spending, will increase beneficiaries' cost
16 sharing, et cetera, 16, can you help me to [off microphone].

17 MS. BOCCUTI: Sure. Oh, the increase. Okay. So
18 considering -- recall this is against a deep cut. So when
19 it just says -- Michael was talking about this is going to
20 be an increase in Medicare spending, well, that gets paired
21 with -- your cost sharing would then be different than it
22 otherwise would be if there was a cut and your premiums will

1 be higher than they otherwise would be if there was a cut.

2 Does that -

3 DR. NAYLOR: This is just directional at this
4 point.

5 MS. BOCCUTTI: Right.

6 DR. NAYLOR: So we don't know exactly what --
7 because it's all I know is depending on the whole picture.

8 MS. BOCCUTTI: Do you want to talk about the next?
9 Well, in the next session, I think we get a little bit more
10 clear. We discuss with CBO, ballpark, so we're not -- we're
11 not in the business of we don't score this, but we make sure
12 that it's in the right realm and in these buckets of what we
13 call the payment. I think Glenn will talk about that more
14 in the next session.

15 MR. HACKBARTH: This also relates back to Mike's
16 question about how the budgetary accounting works for the 1
17 percent increase, and the staff with work with CBO to come
18 up with a number. We don't put a specific point estimate
19 in, but we use sort of buckets. It will be in the biggest
20 bucket. It will be a figure in the tens of billions of
21 dollars.

22 DR. CHERNEW: It's relative to where it would have

1 been, not where it is now. Actually, I can -- say what I
2 was going to say, Mark.

3 DR. MARK MILLER: The reason why -- I know where
4 he was going to go. So in a sense, the baseline says
5 there's going to be a significant reduction in physician
6 payment and then the score is relative to that. But if the
7 Congress were going to come along and not let that happen,
8 then the difference would be much less. And so, in a sense,
9 you can get a gigantic number here and if you calculated a
10 premium increase off of that, you'd be saying, look at the
11 premium increase for beneficiaries.

12 But the difficulty here is, is would the Congress
13 have let this highly scientific cut occur. So answering
14 your question is, we will have these buckets that sort of
15 describe the cost relative to that current law baseline.
16 But you were even, I think, more specific. I'm worried
17 about the beneficiary and the premium, and calculating that
18 premium effect is really squirrely because you don't know
19 exactly what the Congress would have done.

20 DR. CHERNEW: [Off microphone]

21 DR. MARK MILLER: Then they have all that that
22 overlays it. So the kind of factual here starts to get -

1 MS. BOCCUTTI: It's not a big increase from they
2 experience now, which is really, I think, the question,
3 rather than what they would relative to current law of 2012
4 with the SGR cut.

5 DR. DEAN: Just in response to the last
6 discussion, my experience is patients don't make a
7 distinction. They see a role. In fact, most of our mid-
8 level providers get referred to as doctor and it's Dr. So-
9 and-So, even though it's a PA. And I don't know if there's
10 any way to really correct that. Like I say, I think they're
11 responding to a provider in a role and that role is a
12 doctor's role and whether the person has a degree or not
13 isn't really important to them.

14 MR. HACKBARTH: Let's move onto Round 2. Karen?
15 As before, if you could lead with your reaction to the
16 recommendation?

17 DR. BORMAN: I am in my comfort zone with this
18 recommendation with the usual caveats that we have about the
19 SGR, the propriety of it as a platform for the conversation.
20 Not trying to say that this necessarily reflects anything
21 about costs because we don't have physician cost data and so
22 on and so forth. So I'm in my comfort zone with the

1 recommendation.

2 I hope that the community targeted will understand
3 that this is a proactive outreach compared to what, at least
4 legislatively by default, exists. My comments would only be
5 a couple. I think I absolutely support that we need the
6 most sophisticated, the most high quality, most efficient
7 primary care service delivery that we possibly can for the
8 benefit of the Medicare population.

9 I would also point out that we need to just be a
10 little bit careful in understanding that the primary care
11 provider, for some other segments of our population, may, in
12 fact, not be what we typically think of in terms of, just
13 for an example, obstetrics and gynecology and midwives and
14 related other advanced nurse practitioners, oftentimes the
15 primary care provider for women of reproductive age.

16 We would not want to take moves -- we might want
17 to be careful to say, to just remind people we are speaking
18 about a population with multiple chronic diseases, multiple
19 medications and whatever, and that we are targeting some of
20 our commentary about that.

21 Similarly, in the pediatrics world, particularly
22 where there's, I believe, still something of a pediatric

1 subspecialty deficit, we would want to be careful at not
2 trying to generalize to the entire health care system.

3 And then the other piece I would say is that I
4 think coincident with having that spectacular primary care
5 service that we would want to have is we want all of those
6 practitioners, particularly my physician colleagues, to be
7 able to be at the most challenging, top of their license
8 practice environment, and similarly for our nurse
9 practitioner and PA colleagues and whatever.

10 So that coincident with thinking about that is not
11 just how do we make more widgets. It's how do we make a
12 better practice environment that retains people, that
13 leverages them to their skills set.

14 So it isn't necessarily just sort of almost a
15 tacit endorsement of how we're delivering it now, but just
16 throw more bodies at it, that it needs to make sure we're
17 framing the conversation contextually, that similar to this
18 National Workforce Commission, Health Care Workforce
19 Commission and things, we need to think about primary care
20 delivery, not just about the bodies, but also about the
21 roles and the complementary activities that lead to the
22 service that we want to deliver.

1 I think at times in the chapter, we perhaps could
2 do a little better of emphasizing sort of that that's the
3 endpoint, not just playing a number or necessarily money
4 game here. Those things are important and I don't mean to
5 say they're not important, but we have a forest and trees
6 problem potentially there. And to get where we want to go,
7 we want the right number of people, but we want them in the
8 right roles. I think as Tom has alluded to, patients don't
9 necessarily parse that piece out. Certainly my geriatric
10 relatives, who are reasonably well-educated people,
11 certainly would not.

12 MR. ARMSTRONG: I would just tell you I support
13 the direction you're heading with both sets of
14 recommendations. For the second recommendation in
15 particular, I just wanted to amplify how much I agree with
16 the requirement to submit cost and quality data. We haven't
17 really said anything about that, but I just wanted to
18 amplify that point.

19 The only other comment I would make is that the
20 SGR issue aside, it seems that this section and the
21 decisions we're making here really maybe not more so than
22 others, but remind us of all the payment reform issues that

1 we want to talk about, and they get big from bundling
2 payments and ACOs to primary care practices to how -- all
3 sorts of different things. Having said that, I support the
4 direction of these two specific recommendations.

5 MS. HANSEN: I, too, support the two
6 recommendations. I would want to underscore Scott's point
7 about the quality measures that are just going to be
8 absolutely an accountability point, because here we are
9 providing services. So I think the equality of
10 accountability for this spin should be definitely
11 underscored.

12 The second thing relative to the other
13 recommendation that I also support, again I underscore the
14 issue of just the ongoing sensitivity of the beneficiary
15 cost-sharing component, and even though we have a safe
16 harbor year, I think in this process, just our ability to
17 keep an eye on that cost element relative to, frankly, their
18 total income for the average beneficiary.

19 And then finally, as another way to think about
20 the workforce supply in the future as we do studies and,
21 Karen, to your point of having people practice to the top of
22 their preparation and their license, I wanted to just note

1 that last month, the Institute of Medicine came out with a
2 report on the future of nursing and there are 16 states
3 right now that have advanced practice nurses who are really
4 designated as primary care practice individuals.

5 So that number actually probably will continue to
6 grow. So just as we have a large N of baby boomers starting
7 on January 1, there also is a context of primary providers
8 that is beginning to shift in the country. So I think
9 noting the Institute of Medicine report would be really
10 helpful.

11 DR. CASTELLANOS: Let's go ahead and talk about
12 the ASC first. I support that. Two questions I have. I
13 don't understand why we're still using the CPIU. I know we
14 talked about that last year. CPIU has absolutely nothing to
15 do with health care and I would prefer to use the ASC market
16 basket and then we can compare apples to apples.

17 We talked about quality and cost reports. The
18 quality issue is interesting. CMS, in their report to us,
19 at least it was in the literature, saying they didn't have
20 the resources to do this at this time. That's somewhat
21 troublesome. The cost report issues, I've talked to some of
22 the ASC people and they're more than willing to do a scaled-

1 down version of the cost report. That may be something we
2 want to look into.

3 Two things on the physician side, one you can
4 really help us with. The E Prescription, that's a bonus
5 that a physician gets. We get 2 percent this year if we do
6 it by December 31st. Next year it's 1 percent, and then in
7 2012, we get minus 1 percent. CMS has stated they don't
8 have the stuff sort of together to -- and they need a six-
9 month lead time. So unless you have it up and running by
10 July, you're going to get dinged until CMS gets it together.
11 I understand they have resource problems and maybe we could
12 do something to help that.

13 The third thing is, can we have Slide 17 for a
14 second? We talked about primary care levers. That's really
15 important. One of the things we brought up last time is, I
16 think we need to just pay primary care more appropriately,
17 and we talked about care coordination. There are codes
18 there now that are not being funded and that's a big part of
19 primary care. In fact, 40 percent of what primary care does
20 they don't get paid for. So that's something we can look
21 at.

22 The other one that I really don't want to forget

1 is psychiatric care. This is probably the most vulnerable
2 portion of our population. As we discussed last year with
3 them, these doctors drop out of Medicare more than anybody
4 else, they don't participate in Medicare or anything else,
5 they have the lowest hourly wages, and it's a vulnerable
6 population they're taking care of. So I hope, when we look
7 at levers for primary care, we don't exclude psychiatric
8 care. Last year it was excluded under the recommendation we
9 had for primary care.

10 DR. BAICKER: I feel comfortable with the
11 recommendations with the small addition that I think it
12 would be helpful to have a little more information about the
13 carry-forward motivations so that we're sure that the same
14 conditions that generated that apply now.

15 DR. STUART: I support the recommendations.

16 DR. KANE: Yeah, I support the physician one and
17 agree with Kate that it would be helpful to have some sense
18 of what we considered when we first came up with the 0.6 and
19 possibly if there is a better -- I thought we looked at the
20 MEI. I can't remember. If there's a better index that we
21 look at and then if that's been changing in the last two
22 years, that we think about what that implication is. But I

1 like the -- I think the physician one is the best we can do.

2 MR. WINTER: I think my recollection is that we
3 recommended that CMS develop a new appropriate index, or did
4 we recommend a specific alternative? We analyzed this issue
5 last year and presented the results to you. It's in the
6 chapter for March 2010, and in the end, we recommended that
7 CMS collect cost data and use those both to help us evaluate
8 the adequacy of payments, but also to examine whether an
9 existing Medicare market basket or price index would be
10 appropriate for ACS services, the primary candidates being
11 the MEI or the hospital market basket, or whether an ASC
12 specific market basket should be developed. That was our
13 recommendation from last year.

14 DR. KANE: Well, I think if we're throwing out the
15 CPI one, it might be nice to put a different one in and just
16 sort of see if that's changed and if that might change it
17 from 0.6 to something else. I just don't know.

18 MR. HACKBARTH: Well, let me just seek a
19 clarification on ASC. Again, what I have proposed is that
20 we not have a specific recommendation on which we vote on
21 ASCs, because we have no new data to bring to bear on the
22 subject. So in the portion of the chapter that we have on

1 ASCs, we would provide the information in written form that
2 Ariel just summarized in his oral presentation, and then we
3 would have a text box that says, last year this is what we
4 recommended. This year we have no basis for changing that
5 recommendation and so we are not voting on a new
6 recommendation.

7 DR. KANE: Yeah, but that's the question. Is it
8 true that nothing's changed? And if we had been considering
9 some type of market basket something and that's changed, we
10 should take that into account. And it's a really minor
11 thing.

12 DR. MARK MILLER: Where we ended up in that
13 discussion is, the reason that we said this needs to be
14 developed is, is went through and we looked -

15 DR. KANE: I'll go back.

16 DR. MARK MILLER: That's right. We got some cost
17 data and there was some difficulty in how extensive that
18 cost data was, and to the extent that we can compare it, we
19 compared it to the hospital market basket, the practice
20 expense component of the physician and the CPI. And there
21 were sort of parts of it that looked like it kind of behaved
22 like hospital, parts of it that kind of said it behaved like

1 physician, and we said we really didn't have the information
2 to say okay, this is the right measure.

3 So the reason that I think your request is hard is
4 you're saying, tell us whether that thing changed, and we
5 never settled on the thing.

6 DR. KANE: I'll go back and read how we came up
7 with .6 and then I'll decide whether I think there's nothing
8 that's changed. I just can't remember enough how we came up
9 with .6.

10 DR. MARK MILLER: And just to be clear, we have
11 walked through and presented here the data that we do have
12 that has changed in terms of volume and that type of thing,
13 and we can tell you what the change is in the MEI, the
14 hospital market basket, the CPI. It's just your point of
15 like I'm riding one of these horses. We sort of decided we
16 didn't have enough information to pick the horse. That's
17 where we ended up in that discussion.

18 DR. BAICKER: Just to clarify that, I'm totally
19 comfortable saying, here's what we recommended before, we
20 have no better information now. It's different from saying,
21 here's what we recommended before, we have no information
22 that suggests changing that recommendation, implying, so we

1 recommend it again. In that stuff has changed, all the
2 inputs have changed, and there was an update last year that
3 was different from what that update was recommended. So if
4 we really thought that was right last year --

5 MR. HACKBARTH: So it's A that I'm suggesting -

6 DR. BAICKER: And I'm good with that. That's
7 great.

8 MR. HACKBARTH: -- is that we made a
9 recommendation, we really have an inadequate factual
10 foundation to make a recommendation this year, so we're just
11 saying -- we're not even saying roll it over. We don't have
12 the information on this. This is what we recommended last
13 time. We're not voting on it again.

14 DR. KANE: If we're not voting on it, then this is
15 not a big deal.

16 MR. HACKBARTH: Right. We are not voting on it.
17 It's just in a text box that says, this is what we
18 recommended before.

19 MR. KUHN: I support the recommendations.

20 DR. BERENSON: I was going to be that simple, but
21 then I wanted to endorse what Ron just said. In the
22 simulation, the MGMA Urban Simulation, psychiatry, I think,

1 was at the very bottom in simulated income. And it actually
2 does raise the issue of what we used to call cognitive
3 specialties. There was an interesting Wall Street Journal
4 piece a couple years ago about the demise of neuro-
5 ophthalmology. It's a specialty that does sophisticated
6 diagnostic evaluations. They don't have tests. They just
7 get paid for their time and they're going out of business.
8 They're taking out cataracts now.

9 So I think as we do our micro-work on repricing,
10 we should be looking not just around primary care, but at
11 specialties that rely disproportionately on their time and
12 skills, rather than on procedures or tests or things like
13 that.

14 MR. GEORGE MILLER: I support the recommendation
15 for the physician piece. Could you put up Slide 6, please?
16 I'm still a little concerned about the ASCs, particularly as
17 my previous discussion, if you look down at the bottom where
18 you see the minorities, almost three to one, have a big
19 problem finding specialists, and then primarily ASCs are
20 driven by specialists, so that still is a concern to me.
21 Not sure how to address that specifically except for, I
22 think disparity should be a quality of care issue.

1 I don't have a specific recommendation around how
2 to make that quality of care issue, but it seems to me it
3 should be a quality of care issue.

4 Then you have the notion that if both dual
5 eligibles, minorities, and understand Medicaid are going to
6 hospital versus ASC, then that's a cost of care issue
7 because that means that beneficiary is paying more out of
8 pocket to go to a hospital versus an ASC, which we are
9 saying is a lower cost. So that's a double issue, not only
10 a quality of care issue, but they're paying more out of
11 pocket.

12 Again, I think it should be a quality -- disparity
13 is a quality of care issue. I'm not sure how specifically
14 to recommend, but I do want to address that. I think a lot
15 has been said about the outpatient piece. I'm not sure I
16 want to say more, except for remembering the discussion
17 about the hospital portion we had talked about earlier
18 today, tying that somehow or making similar or aligning it
19 similarly with the ASC model. I'm not sure I understood the
20 connection now that we did not have a connection for the
21 recommendation last year or going forward this year.

22 MR. HACKBARTH: I'm not 100 percent sure --

1 MR. GEORGE MILLER: Right.

2 MR. HACKBARTH: -- on quality of care. We said 1
3 percent for hospital outpatient departments.

4 MR. GEORGE MILLER: Right.

5 MR. HACKBARTH: There are two other locations
6 where some of the same services are provided. One is
7 physician offices. The other is ASCs. The physician update
8 recommended is also 1 percent.

9 MR. GEORGE MILLER: That's on the physician side.
10 Right. I got that. The ASC side.

11 MR. HACKBARTH: And there we're not making a new
12 recommendation.

13 MR. GEORGE MILLER: Okay. So we won't vote on
14 anything.

15 MR. HACKBARTH: Cori?

16 MS. UCCELLO: I support the physician
17 recommendation and the non-recommendation for the ASCs, and
18 I look forward to our exploring more of the issues related
19 to SGR, primary care, disparities, and that kind of stuff in
20 the future.

21 DR. CHERNEW: I also support the physician
22 recommendation, although again, like everybody, I think it's

1 difficult to support or even think about in the context of
2 what's either an absurd or shameful way we've treated the
3 physician payment lately. But that's, I guess, not our axe
4 to grind here.

5 I'm going to go against the grain here and say I
6 would rather make a recommendation about ASCs than not, and
7 I think, in fact, we do have new information. We have
8 information about the continued growth in the ASCs and the
9 lack of problems for access to the ASCs. So I don't think
10 the lack of cost data precludes me from thinking about what
11 a reasonable recommendation would be.

12 I guess my preference would be to think through
13 this issue about where payment is relative to the
14 alternative places. You mentioned in an earlier discussion
15 about not wanting to make things worse. This actually does,
16 if I understand correctly, make -- we're not making a
17 recommendation, but if they just continued last year's, that
18 would be a little bit worse because it's 6.6 as opposed to
19 0.1 and 0.1.

20 Incidentally, I would be fine with that because I
21 think these are growing rapidly and I think it's an issue.
22 I think I'm not sure how silence would be taken. So the

1 lack of information doesn't bother me that much, and having
2 a recommendation that's in the range of -- you know, I'm
3 easy enough. You could probably get me to support a wide
4 range of things that are reasonable, but --

5 DR. MARK MILLER: 0.6.

6 DR. CHERNEW: -- 0.6. If you would have come in
7 here -- in all honesty, if you would have come in here and
8 said, we're going to vote on 0.6 and here's why, I would
9 have said that seems reasonable and I would have supported
10 that recommendation. I guess I tend to think that I'd
11 rather have a recommendation than not.

12 MR. BUTLER: Actually, I agree with Mike. I don't
13 feel strongly about it. This isn't the biggest service that
14 we have, but it would be better to formalize it. If we
15 don't -- by the way, I'm okay with the 1 percent on the
16 physician side. The way that the language reads now in the
17 text, it kind of reads, maybe if these guys will behave and
18 give us some data, we might give them an increase. Then the
19 last paragraph says, these things are really vital. And it
20 ends, you know, the last sentence, it is vital that ASCs be
21 paid adequately to ensure the beneficiaries have access to
22 this option.

1 So in the absence of a recommendation, at least
2 the language, you read into this, well, what do you want us
3 to do. So that's what kind of tips me more.

4 DR. CHERNEW: Yeah.

5 MR. BUTLER: Even if it's 0.6, this is what we
6 recommended last year, I think it's a little better than
7 having a hanging text box chad.

8 DR. CHERNEW: Right. I agree with that.

9 DR. NAYLOR: It's always hard to follow these two.
10 Anyway, I support the physician recommendation. I hope the
11 language will continue to reinforce how important primary
12 care is to our future. And I look forward, like Cori and
13 everybody else, to the conversation about the future around
14 SGR and primary care. I would go for a 0.58 increase in
15 this so it appears that we actually knew.

16 MR. HACKBARTH: All right. We're clearly into
17 silly time.

18 DR. NAYLOR: Right.

19 DR. DEAN: I support the recommendations. I tend
20 to agree with Mike and Peter that I think it would be useful
21 to state it explicitly about the SGR -- no, not the SGR.
22 Sorry. I would also support what Ron and Bob have said

1 about being sure that we don't get too locked into a narrow
2 interpretation of where our needs really are. Certainly the
3 most overwhelming, biggest, most frightening shortage is in
4 primary care. Everybody agrees with that.

5 But there are other important shortages, and there
6 are some places where you simply cannot get appointments
7 with psychiatrists, and we need them. And there are others.
8 I mean, that's just an example. So I think we wouldn't lose
9 sight of that.

10 I would also comment just briefly on the working
11 to the top of the license issue, which is clearly an
12 attractive concept, but if it's going to work, we really
13 need to make sure that the options are there so that when
14 one reaches the point, we have an easy transition to the
15 next step, whatever that next step may be. And the Fee-For-
16 Service structure really puts a barrier in place.

17 People are oftentimes, whether it's mid-levels or
18 primary care docs or whoever it is, are oftentimes, or maybe
19 I shouldn't say oftentimes, sometimes reluctant to make
20 those connection for fear that patient won't come back,
21 won't be -- they'll lose, they'll be out of the loop, or
22 whatever, and this, I think, speaks really strongly to the

1 whole idea of payment reform that would help to eliminate
2 some of these barriers that I see really interfering,
3 whether -- and it happens at various levels, like I say,
4 whether it's with mid-level providers or primary care docs
5 or whoever.

6 So I think I would just say, as we've all said,
7 that we desperately need payment reform.

8 MS. BEHROOZI: Oh, boy. I wanted to make some
9 points, I guess, out of my lawyerly head, but being at silly
10 time and layering lawyerly on top of that, I risk really
11 losing everybody. But maybe you and I can talk about this
12 offline.

13 But as far as the physician update recommendation,
14 I'm fine with that. But I don't really understand then.
15 We're picking 1 percent, not with any different empirical
16 basis than we had last year for picking 1 percent. Right?
17 So I don't really see the difference between that and
18 recommending that for the year 2012. Right? That's what
19 this is for? And recommending 0.6 on the ASCs for 2012.
20 You can't really carry, you know, just restate last year's
21 recommendation because it actually says for 2011. So you
22 really do have to say we want to say 0.6 for 2012.

1 And I agree with everybody who says the cost and
2 quality data need is so important. Why would we give up the
3 opportunity to actually make a definitive statement by
4 making it a recommendation again, second year in a row, as
5 opposed to just carrying it forward in a text box? So
6 that's, like I said, maybe a little lawyerly approach to it.

7 And the other comment I would make, some of the
8 data that you referred to in the report but wasn't in the
9 charts in terms of the survey of beneficiaries is about
10 people who have not accessed care. Not just who said, oh, I
11 had no trouble getting an appointment or I had a little
12 trouble getting an appointment, but I didn't go the doctor
13 because I couldn't get an appointment or because I couldn't
14 afford it.

15 I think that it's really important, even though it
16 looks, apparently from the way you describe it, it looks
17 like it's looked before in prior years. I think it's really
18 important information to keep front and center as we're
19 looking at racial disparities and economic disparities go
20 hand and hand and are only going to grow as people are
21 retiring with relatively less retirement -- or more people
22 are retiring with relatively less retirement income.

1 Jeff Colgrin and other's study out of U-Penn that
2 looked at low income beneficiaries with high deductible
3 health plans in Massachusetts showed what a huge deal it is,
4 economic barriers to care are for lower income people. And
5 when you talk about the Deficit Reduction Commission or
6 whomever, whichever one them, talking about unified
7 deductibles and things like that, I mean, there are just too
8 many issues that it implicates, I think, to leave it out.
9 So I'd really suggest putting it into the paper. Thanks.

10 MR. HACKBARTH: Thank you. So based on this
11 conversation, Bob, Mark, and I will talk for sure some more
12 about how to handle ASCs, and then I'll be back in touch
13 with you individually about that.

14 As my Round 2 comment, I just wanted to raise the
15 issue of how we portray the Commission's view of the SGR
16 situation; namely, the repeated, very short term extensions
17 and their implications for Medicare beneficiaries and
18 physicians. As I recall the chapter, and help me out, I
19 remember there's a passage where that is mentioned, but my
20 recollection is you have to read pretty far into the section
21 to get to that point.

22 MS. BOCCUTI: It's in the executive summary. We

1 try to pull it out in the executive summary, but yes, it's
2 down closer to the recommendation.

3 MR. HACKBARTH: Yeah, so what we're thinking is,
4 if we can think about how to make that message as prominent
5 and clear as possible. Based on our previous discussions of
6 this, I think that we're in unanimous agreement that this
7 one-month extension thing is a real problem and a growing
8 problem for the program. Given that, I'd like that message
9 to come through clearly and strongly. Okay. Thank you very
10 much.

11 Moving onto the next area, which is outpatient
12 dialysis services, and I was hoping that we would start to
13 close the gap and get closer to being on schedule, but alas,
14 we are falling further and further from the pack. So we've
15 got a new chance to shine here with our next session and we
16 will really be focused and disciplined in our comments. And
17 if we do them when half the Commissioners have gone to the
18 restroom, we will be really -- right.

19 Okay, Nancy, whenever you are ready.

20 MS. RAY: Good afternoon. Outpatient dialysis
21 services are used to treat most patients with end-stage
22 renal disease. In 2009, there were about 340,000 Medicare

1 fee-for-service dialysis beneficiaries, and total fee-for-
2 service spending was about \$9 billion.

3 My presentation today is composed of two parts.
4 First, I'm going to briefly describe the new payment method
5 for dialysis services that begins in 2011. Then we will
6 proceed with our payment adequacy analysis. At the end of
7 today's presentation, I will present the Chairman's draft
8 recommendation about updating the payment rates for calendar
9 year 2012.

10 So MIPPA mandated that CMS modernize the
11 outpatient dialysis payment method. The statute implements
12 a longstanding MedPAC recommendation to broaden the dialysis
13 payment bundle. In 2011, the payment bundle will be
14 expanded from the treatment itself to also include dialysis-
15 related drugs and labs, laboratory services.

16 Your mailing materials include a table that
17 compares key features of the new payment method with the
18 current payment method. I'm going to summarize some of the
19 key features of the new payment method, but I'm happy to
20 answer any specific questions you might have.

21 The new payment method increases the number of
22 patient-level adjustors and there are one set of adjustors

1 for adult and another set for pediatric patients.

2 The new payment method also includes a low-volume
3 adjustment. This adjustment is expected to help rural
4 facilities.

5 The new system makes outlier payments and the
6 outlier payments are applicable to the portion of the
7 broader bundle that was previously separately billable, that
8 is, dialysis, drugs, and labs.

9 There is a four-year transition into the new
10 payment method. As I said, the first year is 2011. The
11 last year is 2014. By November 1 of this year, facilities
12 had the option to opt into the new payment method
13 completely.

14 Now, there are two budget neutrality factors under
15 the new payment method I want to point out. First, MIPPA
16 requires that estimated total payments for dialysis services
17 be 98 percent of the estimated total amount if the new
18 payment method had not been implemented in 2011.

19 Second, to ensure budget neutrality during the
20 first year of the phase-in, again, because facilities are
21 choosing whether or not to opt into completely the new
22 method or to transition in over the four years, CMS has

1 finalized a 3.1 percent transitional budget neutrality
2 adjustment, and this is applied to all payments, both for
3 the facilities completely opting into the new payment method
4 as well as those transitioning in, and I'm going to talk
5 about this a little bit more in a few minutes.

6 MIPPA includes an annual update for the dialysis
7 sector, and this is new for this sector.

8 And finally, the ESRD Quality Pay for Performance
9 begins in 2012. This is Medicare's first P4P program and it
10 is consistent with our 2004 recommendation. In 2012, it
11 will use three clinical performance measures, one on
12 dialysis adequacy and two on anemia, and facilities submit
13 these clinical outcomes on their claims. There is a two
14 percent withhold for this P4P program.

15 So your briefing papers included some potential
16 issues about the new payment method. I want to highlight
17 three in today's presentation.

18 First, there is limited facility-level information
19 on Dialysis Compare. The Commission has previously stated
20 the importance in monitoring the use of services and quality
21 of care under the new payment method. The new payment
22 method might create incentives for facilities to under-

1 furnish care, including therapies used to treat renal-
2 related comorbidities. CMS's Dialysis Compare website could
3 be expanded to include, for example, information that is
4 readily available to CMS, including additional ESRD clinical
5 outcomes, rates of ESRD hospitalizations, and NED visits.
6 CMS through the ESRD networks already provides facilities
7 how they fare in terms of these measures compared to other
8 facilities in their region and nationally.

9 The second issue I want to discuss with you is
10 this 3.1 percent transitional budget neutrality adjustment.
11 Some stakeholders are concerned that this has been set too
12 high. Remember I said that facilities could make a one-time
13 election to opt into the new payment method. Assuming --
14 CMS assumed that the facilities' decision would be based on
15 what resulted in the greatest revenues, which would not be
16 budget neutral, and that is why CMS is making this
17 transitional budget neutrality adjustment. In CMS's
18 projection, they projected that 43 percent of facilities
19 would opt into the new payment method. However, based on
20 the survey conducted by an industry stakeholder group, it
21 may be that 90 percent of all facilities have opted into the
22 new payment method, suggesting that CMS may have taken out

1 more than was needed. CMS has yet to formally announce how
2 many facilities have opted into the new payment method.

3 The last issue I want to talk about concerns the
4 price proxy used in the market basket index for updating the
5 payment rate. The OIG raised concerns about using the PPI
6 as a proxy for the growth in dialysis drug prices. The OIG
7 contends that this will result in updating the payment rate
8 more than it should be, increasing the gap between payment
9 and cost and affecting price accuracy. CMS disagreed with
10 the OIG recommendation for using a different index, stating
11 that the PPI is best as the new payment method moves
12 forward. At issue here is whether the PPI will accurately
13 capture price changes for injectable dialysis drugs that
14 were previously separately paid for under Part B using ASP
15 and drugs that were previously paid for under Part D.

16 So now I'd like to shift gears and I'd like to
17 move to our payment adequacy analysis. Similar to previous
18 years, there's been a net increase in the number of
19 facilities, and over time, the number of freestanding and
20 for-profit facilities has increased. Of the 5,400 dialysis
21 facilities, about 90 percent are freestanding and about 80
22 percent are for profit, and about 60 percent are affiliated

1 with two large national chains.

2 Here, you can see that both the number of rural
3 and urban facilities continues to grow. Urban facilities
4 have been growing by about 3.7 percent per year since 2005
5 and rural facilities at about 3.2 percent per year.

6 We look at several measures to examine access for
7 beneficiaries. One measure we look at is the capacity of
8 facilities by assessing whether the growth in the machines
9 where people are dialyzed tracks dialysis beneficiary
10 growth. For the past five years, dialysis treatment
11 stations have increased by about four percent per year,
12 while all dialysis patients -- and I want to be specific
13 here, that means both Medicare and non-Medicare -- have
14 increased by about four percent per year.

15 There are few facility closures. Between 2008 and
16 2009, there was a net increase of more than 250 facilities.
17 The facilities that closed, which were about 60, are smaller
18 and less profitable. Our preliminary findings suggest a
19 greater representation of African-Americans in these closed
20 facilities. We estimate that this affects about one percent
21 of African-American beneficiaries.

22 That being said, we did look at all facilities,

1 those that remained in business as well as new facilities,
2 and we see that there is little change in the mix of
3 beneficiaries in terms of their age, sex, and race by type
4 of provider, that is, freestanding versus hospital-based, et
5 cetera.

6 This year, we looked at whether or not there were
7 any changes in the driving distances in miles for
8 beneficiaries and we looked at it in 2004, 2006, 2008.
9 Longer distances -- researchers have shown that longer
10 distances can affect beneficiaries' adherence with their
11 treatment. And this is also another measure to look at the
12 effect of facility closures. So between 2004 and 2008, we
13 see very little change in the distance that beneficiaries --
14 between beneficiaries' residence and the dialysis facility
15 overall and across the demographic groups.

16 We look at changes in the growth of volume of
17 services, and one item we track each year is the growth in
18 the number of dialysis treatments provided to fee-for-
19 service beneficiaries. And as you can see from this chart,
20 these measures closely track between 2004 and 2009. There's
21 about a two percent increase per year change in both of
22 these measures, and that's what you would want to see.

1 We also look at changes in the volume of dialysis
2 drugs furnished, and recall under the current method,
3 providers receive separate payment for dialysis drugs.
4 First, we look at erythropoietin stimulating agents. ESAs
5 manage patients' anemia, which is a common renal
6 comorbidity. ESAs account for about 70 percent of dialysis
7 drug spending. So between 2005 and 2008, there was a
8 decline in per capita use. This decline was driven by new
9 research that showed cardiovascular risks. However, between
10 2008 and 2009, per capita use increased by about two percent
11 -- there was about a two percent increase in ESA epo units
12 per treatment.

13 We also look at changes in the volume of other
14 leading dialysis drugs. Here, we don't look at the per
15 capita use because of the difference in units between drugs,
16 but we look at aggregate volume and we hold price constant,
17 and here, we see a steady increase since 2004 of about six
18 percent per year.

19 We look at a variety of measures to assess changes
20 in dialysis quality. Quality is moving in the right
21 direction for hemodialysis adequacy. This measures how well
22 the dialysis procedure cleans the patients' blood. A high

1 proportion of patients are receiving adequate hemodialysis
2 and that's good. Quality is moving in the right direction
3 for anemia management. The proportion of patients with
4 their anemia under control, that is, with their hemoglobin
5 between ten to 12, the range recommended by the FDA, is
6 increasing. And more patients are being dialyzed with an AV
7 fistula, and that's the recommended type of vascular access,
8 the site on the patient's body where blood is removed and
9 returned during hemodialysis.

10 That being said, improvements are still needed in
11 other parts of care, and this finding is similar to last
12 year's assessment. Patients' nutritional status has shown
13 little improvement over time. This is of concern because in
14 dialysis patients, researchers have linked this measure to
15 higher rates of hospitalization and mortality.

16 Overall rates of hospitalization are not
17 declining. They have remained steady at about two
18 admissions per year.

19 Overall and first year adjusted mortality rates
20 have decreased during this time. Nonetheless, mortality is
21 relatively high among dialysis patients, particularly
22 compared to international comparisons, even after adjusting

1 for case-mix differences.

2 Finally, the proportion of all dialysis patients
3 registered on the kidney transplant waiting list remains
4 low. Rates of renal transplant between 2007 and 2008
5 dropped across all demographic groups.

6 Regarding access to capital, indicators suggest it
7 is adequate. As mentioned earlier, an increasing proportion
8 of facilities are for-profit and freestanding. And there is
9 an increase in the number of facilities, a net increase in
10 the number of facilities. Analysts remain positive about
11 the two largest dialysis providers. Remember I told you
12 that these facilities account for about 60 percent of all
13 facilities. Our assessments suggest that providers, even
14 the smaller chain providers, have access to private capital
15 to fund acquisitions. Investor analysts appear not to be
16 worried about the effect of the new PPS in 2011.

17 Here is the Medicare margin. This is for both
18 composite rate services and dialysis drugs for 2009. The
19 aggregate margin is 3.1 percent. As in previous years, it
20 is higher for urban facilities than rural facilities and it
21 is higher for facilities affiliated with the two largest
22 chains versus those not affiliated with the two largest

1 chains.

2 We project the 2011 margin at 1.3 percent. This
3 includes the MIPPA two percent reduction, the 3.1
4 transitional budget neutrality adjustment, and the 2.5
5 percent 2011 payment update. This projection also includes
6 a conservative behavioral offset to account for efficiencies
7 expected under the new payment method. There is an
8 expectation by investor analysts that providers will become
9 more efficient with respect to their use of drugs and labs.
10 There is also research that suggests that improvements in
11 efficiencies in drug use and lab use can be made.
12 Currently, there are differences across types of providers
13 in the use of drugs and labs. And other research has shown
14 efficiencies if some providers adhered more closely to
15 national clinical guidelines.

16 So we have arrived at the second part of the
17 update process. The Chairman's draft recommendation reads
18 as follows: The Congress should update the composite rate
19 by 1.5 percent for calendar year 2012.

20 In terms of spending versus current law, this is
21 nearly the same as current law. It's actually a slight drop
22 from current law.

1 And I want to just explain that in terms of the
2 beneficiary copayment effect, what we mean here is that any
3 increase in the payment rate increases beneficiary
4 copayment, but no more than current law.

5 That concludes my presentation and I'll try to
6 answer your questions.

7 MR. HACKBARTH: Thanks, Nancy.

8 Could you put up Slide 10 for a second. So the
9 second bullet, that the closures disproportionately affected
10 selected beneficiary groups, I think that's the first -- is
11 this the first time that we've had that finding?

12 MS. RAY: No. Actually, we had that finding
13 several years ago. I'd have to go back and look up --

14 MR. HACKBARTH: Okay.

15 MS. RAY: Not in the past two or three years, but
16 going back further than that, we've had this before.

17 MR. HACKBARTH: Okay. Mitra, Round 1 clarifying
18 questions, Tom, Mary, Peter.

19 MR. BUTLER: A quick question. We get cost
20 information for this. Is there any lesson learned for our
21 previous discussion about the kind of costs that, you know,
22 on ASCs where we may be looking for cost information? What

1 led to us to gather cost information in outpatient dialysis
2 where we haven't, for example, in ASCs?

3 MS. RAY: Oh, well --

4 MR. BUTLER: Or is the amount that's requested
5 something we can learn from so that we can --

6 MS. RAY: I mean, HCFA has --

7 MR. HACKBARTH: From the beginning, almost, of the
8 --

9 MS. RAY: Yes.

10 MR. HACKBARTH: -- the ESRD program, to my
11 recollection, they've collected it right from the outset.

12 MS. RAY: I mean, dialysis facilities -- I hope
13 I'm not misspeaking here -- dialysis facilities, I mean, are
14 an institutional provider, so like hospitals and SNFs, they
15 submit cost report information. So going back through, I'd
16 say at least 1981, 1982 --

17 MR. HACKBARTH: I can't remember.

18 MS. RAY: Yes --

19 MR. HACKBARTH: I've been doing this for a while.
20 I can't remember -- back to 1981, and I can't remember a
21 time that we didn't have cost information on dialysis.

22 MS. RAY: I mean, that's how the original

1 composite rate was set back for 80 --

2 MR. KUHN: And the big distinction, if you
3 remember, from ASCs, there were eight different buckets that
4 basically ASC pricing went into. So to a degree, there
5 wasn't any need to collect that cost information because it
6 was a very crude, antiquated payment system under the old
7 ASC model, and that was another reason why they just didn't
8 collect cost information there.

9 MR. HACKBARTH: Round 1 clarifying questions,
10 Mike, Cori.

11 MS. UCCELLO: Just a quick question, and this may
12 be in the paper but I can't remember. This issue of the, I
13 think it was the change that had the better -- was it the
14 better margins? And so is it because of cost, lower cost
15 due to economies of scale or is something else going on?

16 MS. RAY: There is an economies of scale issue,
17 for sure.

18 MR. HACKBARTH: A purchasing power advantage for
19 the large chains, yes.

20 George?

21 MR. GEORGE MILLER: Thank you for this report.

22 You said that CMS estimates about 50 percent of the dialysis

1 centers would choose to take a new system, but did I hear
2 you say that actually, or the industry reports about 90
3 percent?

4 MS. RAY: CMS estimated 43 percent --

5 MR. GEORGE MILLER: Forty-three percent, okay.

6 MS. RAY: -- and industry estimates about 90
7 percent.

8 MR. GEORGE MILLER: Okay. So what does that mean?
9 I mean -

10 MS. RAY: What that -- if that number holds out to
11 be true, with -- well, it means a couple of things. It
12 means, number one, that facilities feel like that they can
13 operate under the new payment method.

14 MR. GEORGE MILLER: Yes, sooner.

15 MS. RAY: I mean, that's what it means.

16 MR. GEORGE MILLER: Right.

17 MS. RAY: With respect to the transitional budget
18 neutrality factor, it could mean that it has been set too
19 high.

20 MR. GEORGE MILLER: Okay. So do you have the
21 magnitude of that number? What do we -- if it's set too
22 high, how are we going to address that?

1 MS. RAY: I have not estimated -- because CMS has
2 not released the number of facilities that have opted into
3 the new payment method, I have not estimated what that
4 number should be. I know that there was an industry report
5 of what they thought it should be, and I think it was a
6 little less than one percent, but that was from the
7 industry.

8 MR. GEORGE MILLER: Okay.

9 MR. HACKBARTH: I think the inference we can draw
10 from the number of facilities choosing not to go through the
11 transition but to skip over it --

12 MR. GEORGE MILLER: Right.

13 MR. HACKBARTH: -- is that those facilities or
14 chains -- I assume the chains may be a big part of that.

15 MS. RAY: The two large chains have opted into the
16 new payment method.

17 MR. HACKBARTH: Yes. They see opportunities here
18 under the new payment structure to significantly lower their
19 costs.

20 MR. GEORGE MILLER: Their costs, yes. And a
21 follow-up question. Under the bundling of the new payment
22 system that would include all drugs, what happens if a new

1 drug comes online down the road and provides tremendous
2 savings? Under the new payment method, how will that new
3 drug be paid for or accounted for?

4 MS. RAY: That's a good question --

5 MR. GEORGE MILLER: Thank you.

6 [Laughter.]

7 MS. RAY: I want to go back and look at the
8 specific MIPPA provision. The best I can recollect -- I
9 will get back to you on that. I want to just go back and
10 look at the specific MIPPA provision and whether -- I mean,
11 I know it includes the Part B injectables, ESAs -

12 MR. GEORGE MILLER: Right.

13 MS. RAY: I just want to see the language, the
14 other language with respect to that.

15 MR. GEORGE MILLER: Okay. I will save the rest
16 for Round 2.

17 DR. BERENSON: Yes. Can you go to Slide 14,
18 please. I just want to talk a little bit about the quality
19 areas. It strikes me, not being a particular expert in this
20 area but pretty knowledgeable anyway, that the first
21 nutritional status, phosphorous and calcium management,
22 proportion of patients registered on a kidney transplant

1 list, are quality metrics that are proximately related to
2 whether a dialysis center really can have some impact on.
3 When you're talking about mortality rates for a patient with
4 diabetes, almost by definition, have four or five or six
5 chronic conditions. It's really hard for me to understand
6 sort of the causal relationship or what the control that a
7 dialysis unit would have. I guess, is anybody thinking
8 along my way or are they prioritizing into the areas? I
9 mean, the reason I like urea clearance and anemia management
10 as wonderful measures and where we should be starting pay-
11 for-performance is that those are directly related to what
12 the center has control over. So let me ask that question.

13 MS. RAY: Well, I think others do look at the
14 infection-related hospitalizations, again, because that is
15 related to the vascular access, and more use of AV fistulas
16 should reduce infections and therefore reduce
17 hospitalizations --

18 DR. BERENSON: So specific hospitalizations --

19 MS. RAY: Right, right --

20 DR. BERENSON: -- but not just overall
21 hospitalization rates.

22 MS. RAY: And again, that would translate into the

1 mortality, as well. And I think, also, cardiovascular-
2 related hospitalization rates. Again, some would view that
3 -- that has been pulled out separately, for example, like in
4 the U.S. Renal Data System books, looking at that over time.

5 MR. HACKBARTH: And that is something, I think,
6 related. So put up the graph that has the adequacy of
7 analysis, the bar graph. Adequacy of analysis -- adequacy
8 of dialysis. So what was that number again, like 80-some
9 percent?

10 MS. RAY: For what?

11 MR. HACKBARTH: For adequate dialysis.

12 MS. RAY: Oh, that's in the 90s.

13 MR. HACKBARTH: In the 90s.

14 MS. RAY: I'm sorry --

15 MR. HACKBARTH: So is that a function -- and
16 maybe, Bob, you can answer this -- is that a function of the
17 number of treatments per week or the duration of treatments
18 or still other factors?

19 MS. RAY: I would, again, speaking as a non-
20 clinician, I would probably say both the number of
21 treatments as well as the duration.

22 MR. HACKBARTH: Under the payment system,

1 including the new payment system, it's a bundle per
2 treatment --

3 MS. RAY: Yes.

4 MR. HACKBARTH: -- and so there's still an
5 incentive from the facility's perspective to do more
6 treatments. So it would be surprising, given that
7 incentive, to see people not getting enough treatments, and
8 I'm sort of curious as to why --

9 DR. BERENSON: I mean, I think Ron might be able
10 to help here. My understanding is that urea clearance is
11 measuring the success of an individual dialysis and it is
12 not measuring the -- like a hemoglobin A1C is a measure of
13 adequacy of diabetes control over a six-month period, a
14 random blood sugar is just where that patient is at that
15 moment. That urea clearance is really the adequacy of that
16 particular dialysis. That's correct?

17 DR. CASTELLANOS: [Off microphone.] That's right.

18 DR. BERENSON: And so we actually don't have a
19 good measure -- I think the literature is beginning to show
20 that more frequent dialysis gets you better outcomes. We
21 don't have an equivalent of a hemoglobin A1C, I believe, so
22 that we can reward those who are doing more frequent

1 dialyses, but I'm a little out of my league at this point.

2 MR. HACKBARTH: Okay.

3 DR. CASTELLANOS: This is something I deal with or
4 have dealt with in the past and it is a function of the
5 duration of the dialysis and the frequency of the dialysis.
6 It's also a function of the type of dialysis. Peritoneal
7 has less adequacies compared to hemodialysis. But it is
8 related to the duration of dialysis and the time and the
9 frequency.

10 MR. HACKBARTH: Okay. Round 1 clarifying
11 questions. Herb?

12 MR. KUHN: Just, Nancy, one question following up
13 back on this issue of the migration to those that went into
14 the PPS system in the first year versus those that went
15 through the three-year transition. And I appreciate the
16 explanation to George's question. It obviously says that
17 there's plenty of adequacy here, and perhaps as you
18 indicated, the budget neutrality adjustment might be off as
19 a result of that.

20 So my question is this. As new PPS systems come
21 online, there's always a look-back to go back and refine
22 them, because obviously you can't project all the marks out

1 there. And generally, most PPS systems go through a three-
2 or four-year transition and then perhaps a couple of years
3 running them and then it's six years out before the
4 refinements come in place.

5 But this one, with so many of the providers
6 getting in on the first year, what would be the first year
7 we might have data that we could begin to do the look-backs
8 and start to see -- time the refinements? Obviously, I
9 think that would be a much truncated process since so many
10 jumped in the first year. But would it be three years from
11 now when we would have data that we could look at the
12 adequacy of this? Is it something sooner? Is it something
13 later?

14 MS. RAY: I think we won't have data until 2012
15 for the 2011 payment system, and -- yes.

16 MR. KUHN: Okay. So it'd be 2012?

17 MS. RAY: Yes.

18 MR. KUHN: Okay. Thank you.

19 MR. HACKBARTH: This would hardly be the first
20 time that Medicare changed the payment system and evoked a
21 more dramatic response than was anticipated. That was true
22 with the hospital PPS. The changes in patterns of care were

1 quicker and stronger than people anticipated. True in home
2 health and some others, as well. So the good news here is
3 changing the payment methods to encourage efficiency, it
4 works, and obviously we have to take care to make sure we
5 properly measure and reward quality, but this stuff works.

6 DR. KANE: Yes. In the interest of trying to
7 think of measures besides just the clearance for the day of
8 quality, weren't there some kind of before they hit the
9 Medicare level, Medicare eligibility, there's a window of
10 time and how well they're taken care of has an impact on how
11 well their subsequent Medicare period is? I remember this
12 discussion a while back, that there's a period before they
13 go on dialysis, or before they go on Medicare that they're
14 ill and how that gets managed has a big effect on how sick
15 they are when they finally show up for Medicare and whether
16 there's some way to link that to these centers. And I don't
17 know if the centers are the place to look or it's the
18 doctors who are managing them.

19 DR. CASTELLANOS: [Off microphone.] You have to
20 look at the hospitals.

21 DR. KANE: The hospitals that are managing them
22 before they go on dialysis? Just remind me, how long does

1 it -- once a person has end-stage disease, what's the
2 progression between there and when they get on Medicare and
3 start getting treatment?

4 MS. RAY: A person who is under 65 with end-stage
5 renal -- whose doctor certifies that the patient has end-
6 stage renal disease, there's a three-month waiting period
7 and then Medicare -- as long as that individual meets the
8 Social Security, you know, whatever requirements, there's a
9 three-month waiting period unless the patient chooses to
10 undergo self-dialysis training or if the patient is
11 transplanted.

12 DR. KANE: I just seem to remember that we had
13 some concern about what was going on before they ended up in
14 the Medicare program and what happened made a big difference
15 in how well their subsequent Medicare experience was.

16 MR. HACKBARTH: If they're covered by employer-
17 sponsored insurance, then there's a longer period, what, 33
18 months --

19 DR. KANE: Thirty-three months. That's what I
20 remember --

21 MR. HACKBARTH: -- where they're covered.
22 Medicare is secondary --

1 MS. RAY: Yes.

2 MR. HACKBARTH: -- and the employer is primary.

3 MS. RAY: Yes.

4 DR. KANE: And I guess one question is, are the
5 dialysis centers at all places of accountability for that or
6 is it really much more the doctor-hospital? Is there a way
7 to look at that pre-Medicare period when they are most --
8 they can be quite vulnerable to the condition that they end
9 up in when they finally go onto Medicare.

10 MS. RAY: I think some of what you're talking
11 about, the notion that pre-ESRD care, that if a person who's
12 in the Stage IV approaching Stage V of chronic renal failure
13 sees a nephrologist, a specialist, earlier on, that when the
14 person -- if the person eventually ends up to ESRD, that the
15 person won't crash, that there will be a smoother transition
16 and there will be reduced hospital spending. So that's more
17 -- for the under 65 who's not on disability, so not on
18 Medicare, that would be whether they're on other commercial
19 payer or Medicaid and having access -- gaining access
20 earlier on to the appropriate specialty care.

21 MR. KUHN: And even a little further downstream
22 from there, I know CMS is running some demonstrations now.

1 I think the high-cost beneficiary demonstration is looking
2 at CKD or chronic kidney disease and ways to forestall or
3 create the prevention of moving into full renal failure. So
4 there is some better work going on there.

5 DR. KANE: Just in thinking about -- I don't know
6 if you can link it to the quality of the dialysis itself or
7 whether that center's coordination with the other providers
8 is a part of what we want to encourage, but thinking about
9 measures that might also go into this -- again, I'm back on
10 my mode of value and integration and pushing people to look
11 outside their immediate silos to improve the quality -- it
12 might be useful to explore those types of quality measures
13 going forward, and if we ever get to see P4P type things
14 here, that that should be some of it.

15 DR. BORMAN: Just one question. In the materials
16 and in your presentation, Nancy, you mentioned a falling
17 listing on the transplant list, and as a proponent of
18 someone, that that is something that we should look at. My
19 question, however, would be does that reflect a growing
20 shortage of organ donors relative to the number of people on
21 dialysis, or is it that fewer ESRD participants were simply
22 getting evaluated as a potential transplant recipient,

1 because we wouldn't want to say that it's a measure of
2 quality that went down if what it's really reflecting is
3 that there's fewer available organ donors.

4 MS. RAY: Right. That's a good point. And let me
5 be clear that there was -- the percent of people on the wait
6 list -- I mean, I think there was just a -- I mean, it's
7 pretty low, but there was a slight increase. The rate of
8 kidney transplant, there was a decrease in the most recent
9 two-year period. And my recollection is that there was a --
10 I know between 2006 and 2007, there was a drop in the live
11 donor procedures, and I think that partly may be reflecting
12 the 2007 to 2008 numbers.

13 DR. BORMAN: And also a drop in deceased donor --

14 MS. RAY: I need to go back and double-check that.

15 DR. BORMAN: Okay.

16 MS. RAY: There was also between 2007 and 2008 a
17 decline in the rate of newly diagnosed ESRD folks due to
18 diabetes, and that -- again, you don't know how that's
19 playing into everything.

20 DR. BERENSON: I mean, I don't have -- I heard a
21 presentation from a transplant surgeon at Hopkins who feels
22 he's out there suggesting a lack of appropriate referral and

1 that it is a real problem, partly from financial incentives
2 not to refer was his -- I mean, I'm not saying he is right,
3 but there is at least some published literature suggesting
4 that's a problem.

5 DR. BORMAN: And that was the reason that I
6 originally brought it up in a discussion a couple of years
7 ago about ESRD. I just want to make sure that if we're
8 going to stake a statement that it's a quality metric, that
9 we just be sure that we're reflecting those kinds of data as
10 opposed to just mere shifts in the number of people on ESRD
11 versus the number of available organs, because there is a
12 chronic organ shortage, as everyone knows.

13 DR. DEAN: A couple of things. First of all, just
14 a quick thing on the driving distance.

15 MR. HACKBARTH: Could I remind people to say what
16 they think about the draft recommendation as we go through
17 Round 2.

18 DR. DEAN: I'm comfortable with the draft
19 recommendation.

20 On the driving distance, it would be helpful to me
21 to have the range. A lot of things get hidden in an
22 average, and it would be really helpful to know what

1 percentage of people have to go more than 20 miles or 50
2 miles or whatever, because I think that's significant. And
3 you're right, there's a lot of data to say it does affect
4 behavior quite significantly.

5 On the quality issues, as I read through this and
6 also some of the stuff in Tab A about the problems and
7 concerns, it seemed to me that it would really be beneficial
8 to have a much broader-based quality measurement along with
9 some of the things that were listed as hospitalizations,
10 nutrition, I guess, because I think those really are direct
11 things, and there are things that will get missed. I mean,
12 the three that are up there are certainly all reasonable
13 things, but, for instance, hospitalizations due to
14 infections are something that really should be looked at.

15 And the other concern that I have is that the
16 things that get attention are the things that get measured
17 and the worry is that if you have too narrow a measure --
18 too narrow an index of quality, those are the things that
19 are going to get attention and there's a real risk that
20 other things may get pushed aside. So I would really urge
21 that we support a broader-based measure of quality, and I
22 think there are a number of things in the chapter that are

1 actually relatively easy to measure and it would seem to me
2 to be fairly easy to construct a broader-based index,
3 because, I mean, whether it's the albumen levels or numbers
4 of hospitalizations, those are things that are easy to
5 count.

6 DR. NAYLOR: I support the recommendation.

7 MR. BUTLER: I support the recommendation and
8 would, for Glenn's benefit, to make sure that he feels like
9 we're making progress, we've now opined on \$224 billion of
10 expenditures, which is 77 percent of the total. So we're
11 actually three-quarters of the way done.

12 [Laughter.]

13 MR. BUTLER: It just doesn't feel like it.

14 [Laughter.]

15 DR. CHERNEW: If that were only our metric.

16 So I look at the physicians that got one percent
17 update and the hospitals got one percent update and I'm very
18 worried about access in all of those areas, and there's a
19 lot of stuff in here that makes me think I'm not so worried
20 about access. For-profit facilities are entering. There's
21 maybe some efficiencies when we bundle the payment that we
22 haven't figured out if they're exploited. The margins seem

1 sort of to be reasonable, at least -- now, the challenge is
2 this is almost all Medicare in ways, I think, that some of
3 the other ones aren't, so there's some tricks going in
4 there.

5 But I guess I look forward to our call when we get
6 to talk broadly about what this is, but I suppose --

7 [Laughter.]

8 DR. CHERNEW: I'm not not supportive of this
9 recommendation, if everyone supported this recommendation.
10 I think I could have probably seen a lower recommendation
11 and been supportive of that, too.

12 MR. HACKBARTH: [Off microphone.] That's
13 important. As a matter of fact, let me just give people who
14 have already gone an opportunity to react, if they wish --
15 I'm sorry -- give people who have already gone an
16 opportunity to react to what Mike says, if they want to.

17 MS. BEHROOZI: Yes. Actually, being first or last
18 has its problems, and I felt like I didn't really hear
19 enough about why 1.5, why that was the number. So I wasn't
20 quite ready to say, sure, that's great, but I don't know
21 enough to be against it, either, and so -- yes, I guess I --

22 MR. HACKBARTH: Does anybody else want --

1 MS. BEHROOZI: -- why it's different than the
2 others.

3 DR. NAYLOR: I just understood from the
4 presentation and the report about all of these other changes
5 that are going into place at the same time and assumed that
6 this was -- maybe not a good assumption, but because of the
7 two percent reduction by MIPPA, all of this going into play
8 at the same time, that that was the basis. So I could be
9 persuaded --

10 MR. HACKBARTH: Peter?

11 MR. BUTLER: I could be persuaded on one, but at
12 the same time thought that this one did have some careful
13 thought, ended up about where the law is now, and it kind of
14 felt a little bit more sophisticated in terms of how it
15 looked at it than maybe some of our others. So I'd still
16 land on 1.5, but if everybody went with one, I could go with
17 that way.

18 DR. CHERNEW: [Off microphone.] I'm not pushing -
19 - I just want to be clear. I'm not pushing strongly one way
20 or another --

21 MR. HACKBARTH: No --

22 DR. CHERNEW: -- these other areas that --

1 MR. HACKBARTH: This is exactly the process that
2 we need to do, is not just think about the individuals, but
3 also think across the silos and how they relate to one
4 another. So a good comment, and -

5 MS. UCCELLO: Yes, I kind of share some of Mike's
6 thoughts on this, and maybe I need to get over this, but
7 when I look at these, I need to know -- understand a little
8 more where these numbers come from, and looking over --

9 MR. HACKBARTH: Are you talking about the update
10 number?

11 MS. UCCELLO: The 1.5, yes.

12 MR. HACKBARTH: Okay.

13 MS. UCCELLO: And you probably know this, Glenn,
14 but looking at the past recommendations are one, but then
15 the minus two that was in effect -- looking at the projected
16 lower margin, you know, I can see how all of this came
17 about, but, you know, I think there's a range that I could
18 be made comfortable on.

19 MR. HACKBARTH: That's my sense of all the
20 recommendations. There is not a point -- a right number for
21 all of these. For all the years that I have been doing
22 this, it always seemed to me that there was sort of a range

1 of reason that you could be within for any given
2 recommendation. This isn't an arithmetic exercise. This is
3 really about judgment and -- go ahead.

4 MS. UCCELLO: So take that for what it's worth --

5 MR. HACKBARTH: Okay.

6 MS. UCCELLO: -- but I think I also want to echo
7 Tom's comment/concerns about some of these quality issues.
8 I'm concerned about some of these, and to the extent that we
9 can figure out more measures, I think that would be a good
10 thing.

11 MR. GEORGE MILLER: Yes. I want to appreciate and
12 thank Tom for raising the quality issue, because I think
13 between Tom and the statement about why it should be 1.5, I
14 think we should try in the recommendation is to maybe marry
15 those two together, particularly, and Tom mentioned it, in
16 Tab A, there was some angst about the quality in American
17 dialysis centers around America. I'm not saying that's the
18 end-all because the industry came back and pushed back very
19 hard and said all the numbers are wrong, but quite frankly,
20 I remember when the IOM report came out and the hospitals
21 pushed back and said those numbers weren't correct, but from
22 a quality standpoint, when that IOM report came out, the

1 number, rather you debated the number should be zero. There
2 should be zero deaths in America at hospitals, and
3 therefore, I think we had the opportunity here to raise the
4 quality issue, as Tom talked about.

5 And in the chapter, we talked about appropriate
6 dialysis being between 93 and 95 percent, and we thought
7 that was good. Why shouldn't it be at 100 percent? And the
8 same thing for hemodialysis and peritoneal dialysis. Why
9 shouldn't that be the quality goal, to be at 100 percent?

10 So I'd like to make this a pay-for-performance
11 issue around quality, particularly with the margins and the
12 fact that the industry -- if the 90 percent number is
13 correct, they migrated very, very quickly to the additional
14 payment method and this is a good time to put in quality
15 issues, at least in my view.

16 Because I am also then concerned -- the reason I
17 want the quality issues there is, first, because I'm still
18 concerned about the rate of -- the high percentage of
19 Medicare, the high percentage of dual eligibles, and the
20 high percentage of minorities in this group. I'm concerned
21 about the percentage of, for example, African-Americans who
22 are on the renal transplant list and the percentage who are

1 waiting for a kidney transplant. They're both low on the
2 transplant list and yet they make up 32 percent of all
3 patients in end-stage renal dialysis. I find that
4 incredible. There may be good reasons. I haven't read them
5 yet. But I think this is a good time to push the quality
6 issue.

7 So from a policy standpoint, I'd like to see us
8 try to improve the quality standards and then tie them to an
9 improvement, and I, quite frankly, I just don't understand
10 why, as a percentage, African-Americans do not get on the
11 transplant list. I just don't understand that. I think we
12 should set a standard of about a year. It takes time to
13 work them up, but that should be a quality goal, to increase
14 that number, as an example.

15 MR. HACKBARTH: So Nancy --

16 MR. GEORGE MILLER: That's a policy issue --

17 MR. HACKBARTH: -- it may be helpful -- it
18 certainly would be helpful for me if you would just remind
19 us of the link of the new payment system to quality
20 measures. We're going to a new bundle. There is a quality
21 -- a pay-for-performance element in it. Remind us of what
22 the measures are in the pay-for-performance system and how

1 does that work. What are the goals? In order to do well in
2 pay-for-performance, do you have to -- is it an aspirational
3 goal, or is it beat the average, or how does that aspect of
4 it work?

5 MS. RAY: Okay --

6 MR. HACKBARTH: Or hasn't that been decided yet?

7 MS. RAY: Okay. What's been decided is that --
8 okay. The P4P begins in 2012. That's been decided, and it
9 is a two percent withhold. That's been decided. And it
10 uses three measures.

11 MR. HACKBARTH: Right.

12 MS. RAY: It uses a dialysis -- well, I'm sorry.
13 It uses a dialysis adequacy measure, and then it uses an
14 anemia measure of how many are over 12 -- whose hemoglobin
15 is over 12, which is too high, and then under ten, which is
16 too low.

17 MR. HACKBARTH: Right. Then what's the third
18 measure?

19 MS. RAY: I'm sorry, it's -- well, it's one
20 measure on adequacy and two measures on anemia.

21 MR. HACKBARTH: Oh, okay.

22 MS. RAY: Okay?

1 MR. HACKBARTH: Yes.

2 MS. RAY: All right. All right.

3 MR. HACKBARTH: So on adequacy, part of the
4 message I hear George sending is we shouldn't be too easily
5 satisfied --

6 MR. GEORGE MILLER: Right.

7 MR. HACKBARTH: -- with numbers like 90 percent
8 for adequacy.

9 MR. GEORGE MILLER: Right.

10 MR. HACKBARTH: We ought to be really pushing for
11 100. So on the adequacy measure, how is that going to work?
12 If you're at the national average, are you going to do well
13 and get your P4P money for adequacy, or do you have to
14 really excel?

15 MS. RAY: So that's the part that's still -- CMS
16 has issued a proposed rule. The comments have been
17 submitted. A final rule has not been issued on that yet.

18 MR. HACKBARTH: Okay.

19 MS. RAY: And I can come back with you -- come
20 back to you in January with just a little bit more of the
21 specifics, but it's measured against either the -- for each
22 measure, it's measured against either the national average

1 or the facility performance for the first year of the
2 program. And each of the three variables is -- you can get
3 up to ten points. But what CMS has proposed is a higher
4 weight for the anemia under ten than the other two measures.

5 MR. HACKBARTH: Okay.

6 MR. GEORGE MILLER: But nothing addressed the
7 disparities.

8 MR. HACKBARTH: Not in the current set --

9 MS. RAY: Not for 2012, but for beyond, that's
10 something we may want to opine on.

11 DR. BERENSON: First, on the issue that Mike
12 raised, I'm somewhat sympathetic to the point he made. On
13 the other hand, this is a provider who's pretty dependent on
14 Medicare revenues. The margins, the projected margin is 1.3
15 percent, is that what we've got here, and so there's fewer
16 safety valves here. So I'm sort of conflicted. I see your
17 point, and at the same time it may well be that 1.5 is right
18 because of these other factors.

19 Let me -- on the quality, I just would make the
20 following point. I initially was surprised that only, I
21 think, 25 percent of the weight in the pay-for-performance
22 was based on the adequacy of dialysis, but it is over 90

1 percent, whereas the other two measures are down around 60.
2 So I think it sort of makes some sense to emphasize areas
3 where there's more potential gain to be made, so I'm not
4 going to micromanage that decision.

5 With Tom, I would be for more measures. My point
6 earlier, though, is that I would have them be related to
7 what dialysis units do, not to sort of be sort of a global
8 measurement of hospitalization or of mortality, but
9 specifically those related. Now, if we want dialysis units
10 to be medical homes, which in some ways they -- if they had
11 the right personnel, some nurse practitioners, a couple of
12 internists floating around, they could -- and they see a
13 patient three times a week -- they could well become medical
14 homes, in which case we would want to have a different
15 accountability framework. But right now, that's not how it
16 works.

17 Most -- virtually all, I would say, dialysis
18 patients -- well, I'll just -- from my own experience, I had
19 a lot of patients in dialysis, but I was the doctor who was
20 managing their diabetes and their hypertension and their
21 congestive heart failure and it would be hard, I think, to
22 attribute to the dialysis center what was going on with all

1 the other care. If we have ACOs, then the ACO would be
2 responsible to coordinate all of that. So I think we may
3 need a fuller discussion of it. I'm generally in favor of
4 expanding the measurement set, but I know Tom wants to
5 respond.

6 DR. DEAN: It's sort of like the same situation as
7 holding a hospital responsible for readmissions in that the
8 administrators argue, it's outside of our control. I guess
9 my argument would be that, first of all, some of this is
10 under the dialysis center's control, the infections and
11 those kind of things, maybe not total control, but they do
12 have an influence on it.

13 And I think -- I mean, it's an excellent point
14 that this would be a great place for the total care of the
15 patient to be monitored and maybe we could push things in
16 that direction. Maybe we could help with coordination. I
17 don't know. But anyway, I would still argue for a broader
18 index.

19 MR. HACKBARTH: On the first issue of the
20 magnitude of the update and Bob's pointing to the projected
21 1.3 percent margin, Nancy, my understanding -- when you say
22 that's based on conservative behavioral assumptions,

1 conservative in this context means that we may have
2 underestimated how quickly dialysis organizations will
3 respond to the new incentives, so we've been pretty cautious
4 in saying how much they'll change their cost structure?

5 MS. RAY: Yes.

6 MR. HACKBARTH: And on the other hand, we have the
7 evidence that they seem to be leaping at this opportunity,
8 which may suggest that 1.3 is on the -- could be on the low
9 side at the end of the day. Is that a fair -- Nancy?

10 MS. RAY: Yes.

11 MR. HACKBARTH: Okay. Round 2 comments on the
12 recommendation --

13 MR. KUHN: Yes. Just on the recommendation, I
14 think the range we're talking about of one to 1.5 is a good
15 place for us to be discussing this and I'm fine with that.

16 One thing, Nancy, on the quality measures, I'm
17 just curious. Has there been any discussion about a set of
18 CAPS measures for dialysis?

19 MS. RAY: That's still under development, for many
20 years.

21 MR. HACKBARTH: [Off microphone.] So yes.

22 MS. RAY: But it's -- yes. It definitely has not

1 moved as quickly as one might like.

2 DR. KANE: Well, I'm with Mike. I kind of think,
3 given that they're bundling and they see opportunities to
4 create cost savings here, I think I would be more
5 conservative with my update, relatively more conservative.
6 I'm not sure quite where it falls, but I don't know why they
7 would get a better update than a hospital.

8 DR. STUART: If I recall, though, that the
9 hospitals are paying back some of the overpayment. So I
10 think we have to put it in that context.

11 I'm generally comfortable with the recommendation,
12 and if there's further information that comes up before the
13 next meeting, then obviously I'll take that into
14 consideration.

15 I do have a question, though, about the incidence
16 of the disease itself. If you could look at Slide 11, I
17 mean, that looks really steep, but then partly because
18 there's no zero. But if you look at the rate of increase
19 between 2004 and 2009 in terms of the number of people who
20 are on this benefit -- remember, this is just fee-for-
21 service -- the increase is about ten percent over that five-
22 year period. But it's also worth noting that this is a time

1 when there was a dramatic reduction in the total number of
2 fee-for-service beneficiaries because of the increase in MA
3 enrollment. And so it would look as though the -- if you
4 take that into consideration, it could be a much higher rate
5 of incidence if individuals that have this disease stay in
6 fee-for-service.

7 And so my question is, is there any evidence, or
8 do we know the proportion of MA enrollees who are ESRD,
9 because I think we need that information to understand what
10 that rate of increase really is.

11 MS. RAY: So first of all, to be clear, this is
12 the total population, not just incident cases.

13 There has --

14 DR. KANE: [Off microphone.]

15 MS. RAY: Fee-for-service beneficiaries, total --

16 DR. KANE: [Off microphone.]

17 MS. RAY: This is the prevalent population. Okay.
18 All right. And we have seen, according to CMS, an increase
19 in the number of ESRD beneficiaries in MA plans in recent
20 years.

21 DR. STUART: Equivalent to this?

22 MS. RAY: Uh -- I have to go back and calculate

1 the rate of growth. I don't have it for this complete time
2 period. I believe I have it for 2005 to 2008, and I think
3 it -- it's in the paper. It went from something like 22,000
4 to about 43,000. So that's ESRD patients. That can include
5 both dialysis as well as transplant. CMS doesn't break it
6 out just for dialysis versus transplant. There's other
7 measures that suggest that some of that growth is dialysis,
8 though. And I also -- okay. And that's it.

9 DR. STUART: I was going to say, I'd like to see a
10 little bit more on this, because I used the term "incidence"
11 and it well could be that it's because if there's more
12 transplantation and the mortality rate is lower, more people
13 are living longer, and so over time, you get that increase.
14 So trying to understand the underlying nature of this
15 disease within this population, I think, would help us to
16 better understand what the implications of payment are.

17 DR. BAICKER: The general ballpark seems very
18 reasonable to me, but I do -- I am somewhat persuaded by
19 people's thoughts on being a little more conservative,
20 especially in the absence of knowing about selection issues
21 between the plans and what's the differential --

22 MR. HACKBARTH: Conservative being one -- lower or

1 higher?

2 DR. BAICKER: Lower.

3 MR. HACKBARTH: Lower.

4 DR. BAICKER: Lower always seems more
5 conservative, doesn't it? Especially not being sure about -

6 MR. HACKBARTH: [Off microphone.]

7 DR. BAICKER: That's true.

8 [Laughter.]

9 DR. BAICKER: More information on the relative
10 illness and the attractiveness of enrolling diabetic
11 enrollees in Medicare Advantage relative to fee-for-service
12 might be helpful in gauging the magnitude of this update
13 relative to the update for other types of services.

14 DR. CASTELLANOS: I'm going to take a little
15 different approach as far as quality goes. You know, what
16 we're paying for -- what Medicare is paying for is dialysis.
17 They're not paying for management of that patient. They're
18 only paying for management of that patient while he or she
19 is in dialysis. And that's why you have somewhat limited
20 quality measures, hemoglobin, hematocrit, and the
21 effectiveness of appropriateness in the treatment and the
22 dialysis.

1 Now, if you want to increase that bundle and you
2 want to put nephrologists in there or put internists in
3 there that are managing the diabetic patient, then I think
4 we have something else to look at. But we are really paying
5 just for the dialysis. We are not paying for -- we are
6 paying for the management of that patient during dialysis.

7 So I would be a little hesitant before jumping
8 into increasing quality issues. I don't know if -- this
9 bundle just covers dialysis.

10 MR. GEORGE MILLER: How about infections?

11 MR. HACKBARTH: Dialysis special needs plans, any
12 special needs plans that are focused on this population.
13 That is sort of what you would want, is here is a
14 challenging population with a lot of health issues and
15 somebody taking the overall responsibility and looking for
16 all the opportunities --

17 DR. CASTELLANOS: Absolutely, and that's where we
18 should go. I don't want to throw the baby out with the
19 bathwater because there's a lot of good things that we're
20 beginning to see in one of the Medicare programs, and this
21 is the first time we're seeing pay-for-performance as an
22 issue. You don't want to throw that out of the water until

1 you really want to see how it goes.

2 And the other thing is this is the first time we
3 have seen appropriateness criteria applied to anemia
4 management with drug management. This is the first time
5 they've used appropriateness, and this is -- we've talked
6 about this before. I think that's where we have to go in
7 Medicare.

8 MR. GEORGE MILLER: Yes, but Ron, I'm not a
9 physician, but it is the dialysis that causes the anemia,
10 and so shouldn't that be a quality measure and --

11 DR. CASTELLANOS: It's not the dialysis that
12 causes anemia. It's the chronic renal failure.

13 MR. GEORGE MILLER: Well, right, but the dialysis
14 is a function of that, and should --

15 DR. CASTELLANOS: No. The dialysis --

16 MR. GEORGE MILLER: Should not the physician who
17 is managing that dialysis --

18 DR. CASTELLANOS: No, dialysis does not cause --

19 MR. GEORGE MILLER: Well, I shouldn't say cause --

20 DR. CASTELLANOS: It helps getting rid of the
21 byproducts. What happens is the kidneys don't function --

22 MR. GEORGE MILLER: Function, right.

1 DR. CASTELLANOS: -- and that's why you have the
2 anemia. The dialysis doesn't help the anemia at all.

3 MR. GEORGE MILLER: Okay. So that should not be
4 the place where it should be. What you're saying is that
5 should not be the place where it should be monitored.

6 DR. CASTELLANOS: No, I didn't say that.

7 MR. GEORGE MILLER: Okay.

8 DR. CASTELLANOS: I said, this can be one criteria
9 that you measure during dialysis.

10 MR. GEORGE MILLER: Okay.

11 DR. CASTELLANOS: But if you're going to hold
12 somebody responsible for total care, then you really have to
13 go into a special needs program or do something with the
14 total -- these people are train wrecks.

15 MR. HACKBARTH: Yes. So --

16 DR. CASTELLANOS: I mean, Bob, you've seen this.
17 These people have -- comorbidities, 20 percent of them die
18 in the first year.

19 MR. HACKBARTH: So for purposes of this chapter
20 and this report, we can flag the issue of getting the right
21 -- the importance of getting the right quality measures, but
22 deciding exactly how to do that is well beyond the scope of

1 what we can do for this report. So we can come back to it,
2 but we probably need to move on right now.

3 DR. CASTELLANOS: Can I make one more point?

4 MR. HACKBARTH: Sure.

5 DR. CASTELLANOS: And Peter, I was surprised that
6 Peter hasn't picked this up. Five percent of these patients
7 don't have any insurance at all and they're managed in the
8 hospital and the hospital is getting dinged like anything on
9 these patients, okay. So they're providing the total care,
10 and I don't know if that's recognized on the hospital side,
11 but we see very few hospital-based dialysis centers and the
12 ones that you see in the hospital are the train wrecks or
13 the acutes or people without insurance.

14 MR. HACKBARTH: Okay. Jennie?

15 MS. HANSEN: Yes. Sorry I had to step out for a
16 few minutes, so I have just two clarifying questions, back
17 to stage one. What is the average length of time that
18 people are in dialysis? I know people are on a wait list
19 for transplant, but what is the -- is there an average
20 length of time that has been quoted for dialysis users?

21 MS. RAY: You mean before they get a kidney
22 transplant?

1 MS. HANSEN: No, just in general, the average
2 length of stay, so to speak.

3 MS. RAY: Umm -

4 MS. HANSEN: Ron just said, for example,
5 oftentimes if you're very complicated, your survival rate is
6 very short, a year. But on the average?

7 MS. RAY: There is survival -- there's one-year
8 and five-year survival data and I will get back to you on
9 that. I just don't have that right here with me.

10 MS. HANSEN: Sure. That's fine. And then the
11 second clarifying question has to do with the draft
12 recommendation in terms of increased beneficiary cost
13 sharing. Whatever the increase is going to be, there's a
14 correspondence. Is there any information on the fact that
15 cost sharing affects this population more
16 disproportionately, because it's one thing to miss a primary
17 care visit because of the copay, but it's quite different to
18 miss a dialysis treatment because of the copay. Is there
19 any data on that?

20 MS. RAY: So you're -- so let me make sure I
21 understand your question in terms of does the 20 percent
22 affect patients' adherence to coming in for treatment three

1 times a week? Is that what you're getting at?

2 MS. HANSEN: I guess it's actually maybe even a
3 broader question. Is cost of cost sharing an impediment of
4 getting dialysis treatment for this population, because
5 there are -- many people tend to be economically poor, or
6 does Medicaid kick in because it's a dual eligible, in which
7 case it's covered?

8 MS. RAY: I mean, a higher proportion of dialysis
9 patients are dually eligible for Medicare and Medicaid than
10 across -- than compared to all Medicare beneficiaries. That
11 is the case.

12 MS. HANSEN: Okay. Could we have a chart next
13 time just to kind of say what the proportionality is?

14 MS. RAY: Sure.

15 MS. HANSEN: Thank you. And then otherwise, the
16 1.5 to one percent, again, I will wait to hear a little bit
17 more, but it seems within the range.

18 MR. ARMSTRONG: Yes. I would also just agree that
19 that seems like the right range. You know, given how much
20 experience we have with reporting on -- I mean, real
21 information for this population on these services, the
22 relatively sophisticated approach now we're taking to

1 bundling services, given that these programs, these
2 organizations are highly dependent upon Medicare as a source
3 of revenue, relative to some of the other sections and rates
4 we have set, I could make the argument that I would go more
5 toward 1.5 rather than one percent on this particular rate.
6 But I think anywhere in that range seems fine with me.

7 DR. BORMAN: I'm generally comfortable with this
8 range, although I was taken by Mike's points, I think are
9 well taken ones. I do think this is a heavily Medicare-
10 dependent area and so I think we do have to consider that.

11 Just a couple of things. I think that, as Bob has
12 pointed out, the primary manager of the overall individual
13 may vary. It may be someone separate from their
14 nephrologist. In some cases, it is, in fact, a nephrologist
15 who's serving in a dual role, the manager of the dialysis
16 and providing that service, and then the nephrologist who
17 may, in fact, be caring for many things about the patient
18 because their diabetes may, in fact, be the primary thing
19 behind their ESRD and so on and so forth. So I think that's
20 a little bit hard to tease out. I think that if we needed
21 to precisely clarify what's in the service on the physician
22 side, I might suggest going back to the CPT descriptor and

1 what the professional association described as the services
2 that were provided under that.

3 I would say that perhaps it would be fair to
4 consider something like missed dialysis treatments as a
5 quality measure because I think the dialysis center is a
6 part of encouraging the individual to come on a regular
7 basis, and perhaps that might be something in my own
8 experience with patients I would say that they do
9 periodically, opt out of treatment for a variety of reasons,
10 and I think that that potentially could have some use as a
11 measure.

12 I also think that there might be some
13 opportunities relative to monitoring fistula flow rates and
14 how soon intervention happens when abnormal flow rates are
15 detected. So I think as the P4P evolves on this, there will
16 be opportunity for additional dialysis-specific measures.

17 And then, finally, and it's certainly not
18 necessarily a piece of the update, but since we talked about
19 it in terms of the ASCs, we may want to explore a little bit
20 over time whether there are any disclosure issues here. I
21 understand that a goodly chunk of this market is related to
22 publicly-traded companies, but I think a moderate chunk of

1 the remaining market may, in fact, have provider investment
2 and whether or not we should in fairness, since we examine
3 that for other areas, whether we should ask that question
4 here, and it may be that it's a non-issue. But I would just
5 throw that out as part of the future work.

6 MR. HACKBARTH: All right. Thank you, Nancy.

7 So I just looked down at the schedule and I see a
8 session scheduled to end at 4:15 and we're about 4:15. The
9 problem is that it's the next session that was supposed to
10 end at 4:15. So we are just about an hour behind, so I'm
11 going to exhort all of us to be really efficient and let's
12 see if we can close the gap a little bit here.

13 Our next topic is hospice, and, Kim, whenever
14 you're ready.

15 MS. NEUMAN: Good afternoon. We're now going to
16 focus on Medicare hospice services.

17 Before we look at the data, some background on
18 hospice. The Medicare hospice benefit provides
19 beneficiaries with an alternative to intensive end-of-life
20 care. The benefit includes a broad set of palliative and
21 supportive services for terminally ill beneficiaries who
22 choose to enroll. By enrolling, a patient agree to forgo

1 curative care for their terminal condition.

2 More than 1 million Medicare beneficiaries
3 received hospice service in 2009, with total spending of \$12
4 billion. About 42 percent of Medicare decedents in 2009
5 used hospice, with this use rate increasing substantially
6 over the last decade. This growth in hospice use is a
7 positive indicator of increased awareness of and access to
8 hospice services.

9 The hospice benefit was implemented in 1983 on the
10 presumption that it would be less costly to Medicare than
11 conventional end-of-life care. Two major constraints were
12 placed on the benefit:

13 First, to be eligible, a beneficiary must have a
14 life expectancy of six months or less if the disease runs
15 its normal course. Two physicians must initially certify
16 this, and then at specified intervals a hospice physician
17 must recertify this

18 Congress also placed an aggregate cap on the total
19 payments an individual hospice can receive in a year. If
20 the hospice cap amount [about \$22,000 in 2008] multiplied by
21 the number of beneficiaries enrolled by the hospice exceeds
22 total payments to the hospice in that year, the hospice must

1 repay the excess to Medicare.

2 In the past few years, the Commission has spent a
3 fair amount of time on hospice. To recap briefly where
4 we've been, our prior analyses showed rapid growth in the
5 number of hospice providers, mostly among for profits; the
6 number of hospice users has increased; average length of
7 stay has increased, driven by longer lengths of stay among
8 patients with the longest stays. We noted concern about the
9 growth in very long stays because it appeared in part to be
10 driven by incentives in the hospice payment system that make
11 very long hospice stays more profitable than shorter stays.

12 We also identified weaknesses in the
13 accountability of the hospice benefit, including reports of
14 some physicians certifying patients who may not meet the
15 hospice eligibility criteria and questionable relationships
16 between some nursing homes and hospices.

17 To address this, in March 2009 the Commission made
18 recommendations to: reform the hospice payment system to
19 make it better align with hospices' level of effort in
20 providing care throughout an episode; to increase
21 accountability within the benefit; and to collect more data
22 for administration and oversight of the benefit.

1 The Patient Protection and Affordable Care Act
2 includes provisions related to hospice, including some areas
3 touched on by the Commission's recommendations. PPACA
4 allows the HHS Secretary to reform the hospice payment
5 system, as the Secretary determines appropriate, no earlier
6 than fiscal year 2014. PPACA also requires that CMS begin
7 collecting data to inform payment system reform by January
8 2011.

9 In addition, PPACA includes two hospice
10 accountability measures, which are consistent with
11 Commission recommendations. Effective January 2011, a
12 hospice physician or nurse practitioner will be required to
13 have a face-to-face visit with a hospice patient prior to
14 the third benefit period recertification, which is usually
15 180 days, and each subsequent recertification. CMS is
16 required to conduct medical review of hospice claims
17 exceeding 180 days for hospices that have many patients with
18 very long stays.

19 PPACA also includes additional hospice provisions
20 in several areas, such as quality reporting, testing pay for
21 performance, a concurrent care demonstration, and beginning
22 in 2013 adjustments to the market basket updates. I will

1 discuss some of these provisions later in the presentation
2 and would be happy to address others on question.

3 So now we'll take a look at the most recently
4 available hospice data. The number of hospices has
5 increased substantially in the last decade, growing 50
6 percent from 2000 to 2009. This reflects average annual
7 growth of 4.6 percent over the decade and about 2.8 percent
8 growth from 2008 to 2009. The increase in the number
9 hospices has been driven largely by growth in for-profit,
10 free-standing providers. Not shown in the chart, we have
11 seen a modest increase in nonprofit free-standing providers.

12 Hospice use among Medicare decedents has grown
13 substantially in recent years. The percent of decedents
14 using hospice grew from 23 percent in 2000 to 40 percent in
15 2008 and 42 percent in 2009. While hospice use rates vary
16 by demographic and beneficiary characteristics, hospice use
17 rates grew substantially from 2000 to 2008 for all groups we
18 examined: age, race, ethnicity, rural, urban, gender, fee-
19 for-service, managed care, and dual eligibles. From 2008 to
20 2009, use continued to grow among all these groups except
21 Native Americans, whose use in 2009 edged downward one-tenth
22 of a percentage point.

1 Between 2000 and 2009, Medicare hospice spending
2 quadrupled as the number of hospice users and average length
3 of stay increased. In the most recent two years, between
4 2008 and 2009, Medicare spending increased 7 percent, the
5 number of hospice users increased 3 percent, and average
6 length of stay among decedents grew from 83 to 86 days.

7 The increase in average length of stay reflects
8 largely increased lengths of stay for patients with the
9 longest stays. There has been substantial growth in hospice
10 length of stay at the 90th percentile, with an increase from
11 141 days in 2000 to 237 days in 2009. Growth in length of
12 stay at the 90th percentile slowed somewhat in 2009 compared
13 with the more rapid pace seen earlier in the decade. In
14 contrast, the median length of stay has held steady at 17
15 days since 2000, and the 25th percentile is five days.

16 Both the growth in length of stay for very long
17 stays and the persistence of very short stays are a concern.
18 With short stays, there is a concern that beneficiaries may
19 enter hospice too late to receive all the benefits hospice
20 has to offer. With the increase in length of stay among
21 patients with the longest stays, there is concern that
22 financial incentives in the payment system may be driving

1 some hospices to admit patients before they are eligible for
2 the benefit. In fact, there's a group of hospices -- those
3 that exceed Medicare's aggregate payment cap -- that have
4 very long stays across all diagnoses.

5 In 2008, the share of hospices exceeding the cap
6 was roughly 10 percent. Between 2007 and 2008, the share of
7 hospices hitting the cap increased slightly, while the total
8 dollars exceeding the cap declined.

9 Looking at cap hospices, we see that they are
10 almost all for-profit; they have long lengths of stay, even
11 after taking into account patient diagnosis. For example,
12 in 2008, about 47 percent of patients with chronic
13 obstructive pulmonary disease, COPD, had stays exceeding 180
14 days in above-cap hospices compared to 24 percent in below-
15 cap hospices. Hospices exceeding the cap also have a much
16 higher rate of patients being discharged alive than below-
17 cap hospices. In 2008, 44 percent of the discharges from
18 above-cap hospices were live discharges, compared with 16
19 percent in below-cap hospices.

20 The longer lengths of stay and high discharge
21 alive rates for above-cap hospices compared with other
22 hospices may suggest that above-cap hospices are enrolling

1 beneficiaries before they're ready for the Medicare hospice
2 benefit.

3 Currently, there are no publicly available quality
4 data covering all hospices. PPACA requires CMS to publish
5 quality measures by 2012, and beginning in 2014, hospices
6 that fail to report quality data will have their payments
7 reduced 2 percentage points. CMS recently completed testing
8 12 hospice quality measures in seven hospices in New York.
9 The measures tested are generally obtained through
10 abstraction from medical records. Some examples of measures
11 include the percentage of patients with certain symptoms
12 [such as pain, anxiety, or nausea] who received treatment or
13 experienced symptom relief within a specified time period.
14 It remains to be seen whether these or other quality
15 measures will be selected for the public reporting.

16 Now taking a look at access to capital, hospice is
17 less capital intensive than some other provider types. In
18 terms of access to capital among free-standing hospices,
19 publicly traded hospice chains are reporting strong
20 financial performance and likely have solid access to
21 capital; robust entry of for-profit, free-standing providers
22 and modest growth in nonprofit free-standing providers also

1 suggests availability of capital. Hospital-based and home
2 health-based providers have access to capital through their
3 parent providers.

4 Now on to costs. This slide shows the costs per
5 day by provider type. We see that costs per day vary by
6 different provider characteristics. Free-standing hospices
7 have lower costs per day than provider-based hospices. For-
8 profits have lower costs than nonprofits. Above-cap
9 hospices have lower costs than below-cap hospices. Ad rural
10 hospices have lower costs than urban hospices.

11 Length of stay and indirect costs are two factors
12 that contribute to the cost per day differences across
13 provider types. Hospices with longer lengths of stay have
14 lower costs per day. This is consistent with our work
15 showing patients with longer stays receive fewer visits on
16 average per week than patients with shorter stays. Free-
17 standing hospices have longer lengths of stay than provider-
18 based hospices and, consequently, lower costs per day. But,
19 after taking into account differences in length of stay,
20 free-standing hospices still have lower costs per day. This
21 is because free-standing hospices have lower indirect costs
22 than provider-based hospices, which suggests that the costs

1 for provider-based hospices may be inflated by the
2 allocation of overhead from the parent provider.

3 The next slide shows our estimates of aggregate
4 Medicare margins for hospices over time. From 2002 to 2008,
5 the aggregate hospice Medicare margin has fluctuated between
6 4.5 and 6.5 percent. In 2008, the aggregate margin was 5.1
7 percent, down from 5.8 percent in 2007.

8 A couple points about how we estimate margins.
9 Like last year, on the revenue side we exclude Medicare
10 overpayments to cap hospices. On the cost side, consistent
11 with our methodology in the other sectors, we exclude
12 Medicare nonreimbursable costs. This means we exclude
13 bereavement costs and volunteer costs.

14 The exclusion of bereavement and volunteer costs
15 raises an issue. The statute requires that hospices offer
16 bereavement services to the family members of a deceased
17 Medicare beneficiary, but the statute also specifies that
18 bereavement services are not reimbursable. The statute also
19 requires that hospices use volunteers to provide a certain
20 percentage of services. The costs of bereavement and
21 volunteer services are not insignificant. If they were
22 included in our margin calculations, the margins would be

1 1.8 percentage points lower. So in developing his draft
2 recommendation for the hospice update, the Chairman has
3 contemplated this issue.

4 The next slide shows hospice margins overall and
5 by type of provider. Again, the aggregate margin is 5.1
6 percent. You'll notice this is a 2008 margin, whereas we
7 have 2009 margins for other providers. This one-year lag
8 occurs because we get information on hospice revenues from
9 the Medicare claims data, and the claims data have time
10 lags. For 97 percent of hospices, we do have claims data
11 for the 2009 cost reporting year, and margins for these
12 providers increased from 2008 to 2009 by 1.1 to 1.5
13 percentage points.

14 In terms of hospice margins by type of provider,
15 in 2008 free-standing hospices had a margin of 8 percent
16 compared with 2.7 percent for home health-based hospices and
17 -12.2 percent for hospital-based hospices. Part of the
18 reason for these margin differences is the higher indirect
19 costs among provider-based hospices. If home health- and
20 hospital-based hospices had indirect cost structures similar
21 to free-standing hospices, we estimate it would increase
22 their margins by 8 to 11 percentage points. And it would

1 increase the overall industry-wide Medicare margin by 2
2 percentage points.

3 In terms of margins by type of ownership, for-
4 profit hospices had margins of 10 percent compared to 0.2
5 percent for nonprofit hospices. Focusing on free-standing
6 nonprofits whose costs are not be affected by allocation of
7 overhead from a parent provider, margins are higher -- 3.8
8 percent. Urban hospices have more favorable margins than
9 rural hospices. And we also see that margins increase with
10 average length of stay.

11 Looking at providers by average length of stay
12 quintiles, margins increase for each successively higher
13 average length of stay quintile, until the highest quintile
14 where margins dip slightly. The dip in the highest quintile
15 reflects the fact that some hospices in this group exceed
16 the cap and must return overpayments. Above-cap hospices
17 had margins of 19 percent before the return of overpayments
18 and 1 percent after the return of overpayments. Below-cap
19 hospices had margins of 5.5 percent, higher than the 5.1
20 percent industry-wide Medicare margin.

21 Finally, hospices with a high share of patients in
22 nursing facilities and assisted living facilities have

1 higher margins than other hospices. Hospices in the top
2 quartile in terms of percent of patients in nursing and
3 assisted living facilities had a margin of about 13.7
4 percent compared to -3.3 percent for hospices in the bottom
5 quartile.

6 The projected 2011 hospice margin is 4.2 percent.
7 To make this projection, we start with the 2008 margin and
8 take into account the following: full market basket updates
9 to the payment rates for 2009 to 2011; cost growth generally
10 in line with projected input price increases; small changes
11 to the wage index values in 2010 and 2011; a reduction in
12 the hospice wage index budget neutrality adjustment in 2010
13 and 2011, which reduces payments by about 1 percent;
14 additional costs related to the face-to-face recertification
15 visit requirement beginning in 2011.

16 With regard to 2012, there is one additional
17 policy to note. Hospices payments will be reduced an
18 additional 0.6 percentage points in 2012 due to the
19 continued phase-out of the wage index budget neutrality
20 adjustment.

21 So, in summary, the supply of providers continues
22 to grow, driven by for-profit hospices; number of hospice

1 users has increased; length of stay has increased among
2 patients with the longest stays; access to capital appears
3 adequate; the 2008 margin is 5.1 percent; and the projected
4 2011 margin is 4.2 percent; these margin estimates do not
5 include bereavement and volunteer costs, about 1.8
6 percentage points.

7 Taking into account all of these factors, the
8 Chairman has developed the following draft recommendation:
9 "The Congress should update the payment rates for hospice
10 for 2012 by 1.5 percent."

11 The implications of the recommendation would be a
12 decrease in spending relative to current law. We expect no
13 adverse impact on beneficiaries' access to care or
14 providers' willingness and ability to care for Medicare
15 beneficiaries. As you know, this draft recommendation would
16 affect aggregate payments, not the distribution of payments
17 across providers.

18 The Commission has made a recommendation to revise
19 the hospice payment system, which would affect the
20 distribution of payments across providers. In March 2009,
21 the Commission recommended that hospice per diem payments be
22 relatively higher at the beginning and end of the hospice

1 episode and lower in the middle period to better align
2 payments with hospices' level of effort throughout an
3 episode. These reforms would have the effect of changing
4 the distribution of payments across hospices, moving some
5 revenues from hospices that are more profitable to hospices
6 that are less profitable. We plan to re-run this
7 recommendation in the March 2011 report since the Secretary
8 has been given discretion on the structure of a revised
9 payment system.

10 We also plan to re-run a recommendation in the
11 March report for OIG studies of a number of issues, such as
12 hospices/nursing home financial relationships and
13 differences in patterns of nursing home referrals to
14 hospices; enrollment practices of hospices with unusual
15 utilization patterns, and hospice marketing practices. The
16 OIG has work underway in several of these areas,
17 particularly with regard to hospice and nursing facilities.
18 Since many but not all aspects of the recommendation are
19 under study, we plan to repeat the recommendation.

20 With that I conclude my presentation and look
21 forward to your discussion and any questions.

22 MR. HACKBARTH: Thank you, Kim.

1 So round one clarifying questions, starting on my
2 right-hand side.

3 MR. ARMSTRONG: You expressed concern about the
4 cost of volunteers. I thought volunteers were free, so I
5 just didn't understand what that would be.

6 MS. NEUMAN: There is the cost of recruitment of
7 the volunteers and training of volunteers, things of that
8 sort. So the volunteers themselves are free, but the costs
9 associated with getting them and having them do things is
10 not.

11 MR. ARMSTRONG: Okay. In that area, you implied
12 that this cost had some influence over the final
13 recommendation. Did it have very much influence? It was
14 hard to tell from the comments that you made.

15 MR. HACKBARTH: Yeah, I would say it did have some
16 influence. So why don't you put the relevant numbers up
17 there.

18 MR. ARMSTRONG: Slide 17.

19 MR. HACKBARTH: Yeah.

20 MS. NEUMAN: This here?

21 MR. HACKBARTH: Actually, the numbers with the
22 projected margins is the one I was thinking of.

1 MS. NEUMAN: So the 4.2?

2 MR. HACKBARTH: Yeah, so 4.2 percent and the
3 combined bereavement and volunteer expenses were 1.8, as I
4 recall, so these are things that they're required to do but
5 by law aren't -- not by law, but are not counted as
6 allowable costs. And so I'm saying since they're required
7 to do them, it seems to me that they are real costs, and we
8 may want to think about what the margin would be taking them
9 into account, and so we would be down from 4.2 to 2.4.

10 MR. ARMSTRONG: Thank you. That answered my
11 question.

12 MS. HANSEN: This is great. I just wanted to ask
13 the second aspect of the unpaid-for service, which is the
14 bereavement services. I was trying to recall the
15 description. Have we had a description as to what that
16 profile is of the activity around bereavement, what that
17 service amounts to, the frequency? Or did I recall that it
18 goes for an entire year?

19 MS. NEUMAN: I believe it's 13 months after the
20 patient is deceased, and it's for the family members of the
21 Medicare beneficiary. And I don't believe that we have data
22 that gives us a sense of how many visits or what kinds of

1 services that the family members are receiving. But that's
2 something that I can do some more looking at.

3 DR. CASTELLANOS: Good presentation. The
4 concurrent demonstration project, is there any follow-up on
5 that that you know of at this time?

6 MS. NEUMAN: My understanding is that that project
7 is still in development. They have not yet released a
8 timeline for implementation. It's supposed to be up to 15
9 sites where they're going to test what the effect is of
10 allowing folks to elect hospice and continue curative care
11 at the same time. And so it would be a three-year project
12 in up to 15 sites.

13 DR. CASTELLANOS: Any follow-up on the fraud and
14 abuse that was discussed, that issue?

15 MS. NEUMAN: As I stated at the beginning of the
16 presentation, the Congress adopted the recommendation that
17 the Commission made for the medical review of the long stay
18 claims. So we'll see as the year goes forward how that
19 goes. I don't have any additional updates for you right now
20 on fraud and abuse.

21 DR. CASTELLANOS: Hospice excludes some of the
22 Medicare nonreimbursed costs. Does any other provider have

1 that? In other words, they're excluding some of the
2 nonreimbursable charges, you know, the volunteer costs --

3 MR. HACKBARTH: Yeah, there are for other
4 providers costs that providers incur that are not counted as
5 allowable costs. The one that always sticks in my mind is
6 TVs and the hospital cost report and things like that. The
7 difference here, I think -- and people can correct me on
8 this -- is that hospitals are not required to provide TVs,
9 and it's not allowed as a cost. Here hospices are required
10 to provide the volunteers and bereavement services, and then
11 we say it's not allowable. And it's that juxtaposition that
12 makes me think, well, maybe we want to take that into
13 account in our recommendation.

14 DR. CASTELLANOS: Okay. And the last is a
15 rhetorical question. The base rate and the payment rates
16 have really not been recalibrated for almost 37 years. I
17 know we've made some recommendations. Can you give me a
18 good explanation why that hasn't been done?

19 MS. NEUMAN: That's a difficult question to
20 answer. We can refer back to our discussions last year when
21 you made the recommendation to revise the hospice payments.
22 There was some discussion back and forth about aggregate

1 payment levels, and a decision was made to recommend
2 something budget neutral at that time. So to the extent --
3 and that's what the Congress, in fact, put into the law. If
4 the Secretary does change the payment system in 2014 or
5 thereafter, it will be budget neutral. And, you know, there
6 is a question about aggregate payments that we go through
7 every year. That's sort of kind of two separable things.

8 MR. HACKBARTH: Ron, part of what motivated our
9 originally taking a look at the hospice payment system was
10 that it was a system that was developed a long time ago and
11 never really looked at or refined or improved. And as we
12 began to look at it, we thought, hey, it is ripe after 30
13 years for some changes.

14 DR. CASTELLANOS: Thank you.

15 DR. STUART: I have a couple of questions on Slide
16 18. First is a math question, and maybe I'm missing
17 something here, but when I add up the number or the percent
18 of hospices that are for-profit and nonprofit, that's 52
19 percent, if I've got this right, and 35 percent. I end up
20 with 87 percent. Do we have some sort-of-for-profits that
21 are not allocated here?

22 [Laughter.]

1 MS. NEUMAN: There's government and other
2 ownership structures that are missing.

3 DR. STUART: Okay. So they're not included in the
4 not-for-profit.

5 MS. NEUMAN: Correct.

6 DR. STUART: Right, okay. And then remind me, in
7 terms of these profit margins, why do we exclude the cap
8 overpayments? I think what that means is that the real
9 profit that a hospice earns after they pay it back is lower
10 than what we have indicated here. Is that correct?

11 MS. NEUMAN: So if a hospice exceeds the cap, they
12 have to repay the excess back to Medicare. So in our
13 margins, that excess that they have to repay, we don't count
14 that as revenues to them.

15 DR. STUART: Oh, okay. So it's a question about
16 what exclude means here. So when you say that --

17 DR. BAICKER: [off microphone] It's net effect.

18 DR. STUART: -- it excludes the cap overpayments,
19 it means that those are reduced -- those are taken into
20 account in terms of the revenue side.

21 MS. NEUMAN: They're subtracted from the revenue
22 side.

1 DR. STUART: They're subtracted.

2 MS. NEUMAN: Yes.

3 MR. HACKBARTH: [off microphone] -- cost side.

4 MS. NEUMAN: It doesn't affect the cost side.

5 MR. HACKBARTH: Because those aren't allowable --

6 MS. NEUMAN: If they've exceeded the cap, then the
7 policy is that Medicare has paid too much for the care that
8 they've provided, and so they repay some of that money to
9 the government. It doesn't change the amount of costs they
10 incurred to provide that care.

11 MR. HACKBARTH: Okay.

12 MR. KUHN: Kim, just a quick question. If I
13 remember right, those institutions that exceeded the cap are
14 kind of clustered in a set of six or seven states. Is that
15 correct?

16 MS. NEUMAN: Yes, there's definitely a clustering
17 of states, yes.

18 MR. KUHN: And how about the growth? Is that also
19 a clustering, or are we seeing that nationwide?

20 MS. NEUMAN: No, it remains relatively clustered.

21 MR. KUHN: So if that's the case -- and when we
22 measure access, adequacy and access to care, because of that

1 clustering in those states, do we feel pretty confident that
2 we are seeing good access in those areas where we're not
3 seeing as high growth as those in those cluster areas?

4 MS. NEUMAN: There is a chart in your mailing
5 materials that shows the ten states with the highest use of
6 hospice among decedents, so the highest percent of Medicare
7 decedents using hospice. And when we look at the percent of
8 hospices in those states exceeding the cap, we see the whole
9 gamut, from a couple states that have high rates of hospices
10 exceeding the cap to a number of states that have none or
11 very low amounts of hospices exceeding the cap. So we don't
12 think that the cap is what's sort of driving our hospice use
13 rates. It's kind of unrelated.

14 MR. KUHN: I was just thinking more of the growth
15 of new hospices and just making sure that if we are
16 clustered, if those areas where we're not seeing such high
17 growth, that we do have good access in those areas as well.

18 MS. NEUMAN: I think that we have seen -- there
19 are a couple states where we have seen some declines in the
20 number of hospices, and we can look at that issue again to
21 sort of check that out. Something that's not in this year's
22 mailing materials but we had last year that sort of speaks

1 to this issue of number of providers and access is that if
2 you plot the number of providers per beneficiary or per
3 thousand beneficiaries in the hospice use rates, it's a
4 complete scatter. There is no relationship between the
5 number of hospices per beneficiary and how many people
6 enroll, because unlike something that has a fixed, like
7 facility, hospice could be big or little. So the number
8 doesn't necessarily reflect capacity to serve.

9 So I will definitely take a look and see if there
10 are a few states where we could have concerns about the
11 growth, but overall we haven't seen a relationship between
12 numbers and access.

13 MR. HACKBARTH: My recollection is that Oregon is
14 a high-use state but a low-growth state, for example.

15 MS. NEUMAN: Yes.

16 DR. BERENSON: I have read elsewhere that there
17 have been legal challenges to the way CMS has administered
18 the cap with something about them allocating into a single
19 year's spending that occurs over two years and, therefore,
20 artificially having a cap, and that courts have upheld the
21 challenge. Could you sort of elucidate for us?

22 MS. NEUMAN: Sure. The crux of the issue is that

1 the way the statute is written, if a beneficiary switches
2 providers, they need to be able to allocate the
3 beneficiary's time in hospice, days in hospice across those
4 providers. And the way CMS does the calculation is they
5 count the beneficiary in the calculation in the first year
6 they enroll. So CMS is not allocating exactly as the
7 statute says. But if you took the statute to the extreme,
8 it's really impossible to do it exactly as the statute says
9 because you would literally have to wait until every person
10 who was in the hospice passed away before you could know for
11 sure what their total hospice use was over their lifetime
12 and how to allocate appropriately across those years.

13 So what has happened is a number of hospices have
14 challenged the way CMS is doing it, and a number of courts
15 have found against CMS saying that they're not doing it as
16 the statute has suggested. So in most of those cases, what
17 has happened is it has been remanded back to CMS to do a
18 recalculation, and in some cases, hospices have owed more,
19 not less, and vice versa.

20 So this is still going on. There's still a fight
21 going on about how this is being done, but it hasn't negated
22 the cap in most cases. It has just -- it's an agency about

1 the amount, at least as the court has seen it. The court
2 has not said that --

3 DR. BERENSON: So this doesn't have a prospect
4 then of basically negating the cap such that there would be
5 more money flowing to those high-cost hospices and higher
6 net total margins that we should be considering in the near
7 future? You don't think it's relevant to our discussion?

8 MS. NEUMAN: It's possible that our estimates of
9 the amount of cap overpayments could be incorrect. We could
10 have too high an estimate. Maybe they don't have to repay
11 all of it. So it is an issue to consider.

12 If you look at the margins for below-cap hospices,
13 we see about 5.5 percent in 2008. So if you were really
14 worried about this, you could think about as one option
15 focusing on those folks because that would take this issue
16 off the table.

17 MR. GEORGE MILLER: I'm trying to get my hands
18 around the growth in the for-profit and the length of stay
19 versus not-for-profit. Am I correct in that most of the
20 growth in hospice over the last several years has been in
21 for-profits and that they have the longest length of stay?
22 Which generates more profit for them because they're able to

1 spread their costs.

2 MS. NEUMAN: Right, so most of the growth in
3 providers is for-profit, and length of stay is higher in
4 for-profit than nonprofit, even within diagnoses.

5 MR. GEORGE MILLER: And then the cap overpayments
6 have been mostly in for-profits.

7 MS. NEUMAN: Right. But, again, for-profit is 50-
8 some percent of providers, and the folks who are hitting the
9 cap is 10 percent, so just as a frame of reference.

10 MR. GEORGE MILLER: Right, right. Thank you.

11 MS. UCCELLO: I'm just thinking through some of
12 the issues related to the short stays, because these are
13 just as troubling. But it's not necessarily the facilities'
14 or the hospices' fault that people are coming to them too
15 late. But that said, I'm still interested in what -- and
16 it's probably small just because by definition we're talking
17 about smaller dollars because they're shorter stays. But if
18 we took out these low 20 or 25 percent of stays from our
19 margin calculation, how much would that kind of increase the
20 margin?

21 MS. NEUMAN: Is what you're saying that if there
22 was a different sort of distribution of length of stay among

1 people who are in hospice, what would the margins look like
2 today?

3 MS. UCCELLO: In effect, yeah. If you just take
4 out those low folks, or maybe bump them up. I don't know.
5 But I'm just trying to get a feel for how much that's
6 driving some of the margin versus not. Again, I think it's
7 probably small just because -- in terms of dollars it's a
8 disproportionately smaller share.

9 MR. HACKBARTH: So if you them out, that would
10 drive up the average margin. But I'm not sure where you go
11 with it.

12 MS. UCCELLO: Well, I'm just --

13 MR. HACKBARTH: What's the policy implication? I
14 can understand the math that you're thinking about.

15 MS. UCCELLO: Yeah, well, and I think I'm just
16 thinking through it because you don't want to penalize the -
17 - but if you had a policy or if there were policies that
18 could help get people in there sooner, then that itself is
19 helping the margins of the hospice. I'm just thinking out
20 loud, but, you know, just -- I'll just stop.

21 MR. HACKBARTH: Presumably hospices have an
22 incentive to reach out and be available in the community and

1 get patients early, at an appropriate time when they can
2 help.

3 MS. UCCELLO: So then it is as much as --

4 MR. HACKBARTH: It's not that there's not an
5 incentive to do that. But apparently there are other
6 barriers that stand in the way.

7 MS. NEUMAN: We had a expert panel about a year
8 and a half ago, and we talked about this issue, about the
9 short-stay patients, and sort of what kinds of things could
10 be done to facilitate a more timely entry for those folks
11 who were interested in hospice. And, you know, our expert
12 panelists from the hospice industry cited a lot of issues
13 that, you know, really are outside of the hospice payment
14 system, things like, you know, social and cultural issues,
15 the sort of school of thought in medical practice about
16 trying to cure, you know, sort of very acute care-focused
17 kinds of practices. And, you know, the other thing that
18 people talk about is sort of the fact that you have to give
19 up -- you know, you have to give up curative cure to elect
20 hospice. So the demo that's going to happen will give us
21 some sense of, you know, what the impact of a change like
22 that might be.

1 MR. BUTLER: I'm trying to come to grips with
2 whether I'm going to support 1.5 or 1.0. It's tipping my
3 hand, but it's based on a little bit of a question here.

4 Go back to 18 now, and the nonprofit is sitting at
5 -- the free-standing, for example, is 3.8. And I notice in
6 the chapter the bereavement cost, for example, of nonprofits
7 is 2 percent and for-profits is 1.1 percent, which makes me
8 a little worried or concerned, you know, different levels of
9 service. And I'm suspecting -- and this is a question --
10 that our recommendation to the Secretary to ask the
11 Inspector General to look at the bad behaviors would be more
12 likely to be skewed to the for-profit side than the
13 nonprofit side. And I don't know that, but if that were the
14 case, that would tend to pull that margin down, if they
15 follow through on it. And if all that is true, then I would
16 kind of think, well, the rest probably needs the full 1.5
17 percent, as I'm looking at this. But unless, you know -- so
18 if the Inspector General really was successful, I have no
19 idea about the potential size of the impact and where it may
20 land in this profile.

21 MS. NEUMAN: It's really hard to predict. You
22 know, for-profit providers have longer stays than

1 nonprofits, but we see long stays among both categories.
2 There are providers in both categories that have very long
3 stays that could be, you know, sort of looked at and, you
4 know, it's hard to know what would happen of any kind of
5 looking. But I can't really predict for you. It's pretty
6 hard to predict what will come of that.

7 DR. MARK MILLER: I don't know why I'm compelled
8 to say this, but the other thing that we are going to re-run
9 is the change in the payment, the underlying payment system,
10 and I need some help to remember here. That does
11 redistribute from high profit to lower profit. It's sort of
12 the other side of your coin, like if they were to do that,
13 that would shift money in the other direction from high
14 profit to low profit, from longer stay to shorter stay, from
15 it turns out for-profit to not-for-profit. I think I said
16 most of that right.

17 MR. HACKBARTH: Yeah, and if that were to happen,
18 then you might say with that redistribution then you can
19 have a lower update because now the hospices at the low end
20 of the distribution would be paid more and lifted up, and it
21 would be financed out of lower payments at the long end of
22 the distribution. And you could say with that

1 redistribution, oh, we can live with a smaller increase in
2 the pie, but so long as you have a severe maldistribution,
3 then, you know, that may incline you to say that we need a
4 little bigger number for the people at the low end.

5 This is something that comes in a lot of different
6 sectors. What do you do when you've got this really broad
7 distribution of margins and you're not confident in how the
8 money's distributed?

9 DR. NAYLOR: I may tip my hand the other way in
10 this world. I'm wondering -- you know, data has just come
11 out from many sources about the rehospitalization rate,
12 hospitalization rate and rehospitalization rate of people
13 with cognitive impairment, multiple functional deficits, and
14 48 percent of the people in the Medicare beneficiaries are
15 people over 85 that are receiving hospice. So I'm trying to
16 put together, then, what are the data for the 40.9 percent
17 in the hospice benefit in terms of their cost, Medicare cost
18 in the last six months of life versus the other than 50 --
19 whatever they are, the remaining, who are not in this
20 service? I mean, because you start at the beginning saying
21 this is something we want to encourage, so I'm wondering can
22 you give us a sense of what are the costs for the people

1 that are not accessing this service relative -- Medicare
2 costs relative to those?

3 MS. NEUMAN: So we have not done our own estimate
4 of the costs of people who enroll in hospice at the last six
5 months of life, over the last year of life compared to folks
6 who do not. There is research looking at that, and what I
7 can tell you is that whether hospice saves money or costs
8 more money depends on a number of things.

9 For the first month or two -- the last month or
10 two months of life, hospice saves money because you reduce
11 high-cost inpatient care in those time periods. The
12 research is less clear on exactly where, but maybe at the
13 third month, fourth month, hospice starts to -- before the
14 third or fourth month before the time of death, hospice
15 starts to cost more money than it saves. So you're saving
16 more money in the last two months of life. As you get out
17 further, you're costing more, and at some point the savings
18 from the last two months will be outweighed by the cost as
19 length of stay gets longer and longer. And it also depends
20 on diagnosis. Certain diagnoses use inpatient services more
21 than others.

22 So there's not a strict hospice saves money or

1 doesn't and this is how much. It really depends on a lot of
2 characteristics: how long you're in hospice, you know, what
3 your condition is, the practice patterns in an area, all of
4 that.

5 DR. NAYLOR: And so the projected recommendations
6 will help address that in terms of the readjustment of
7 payments, more here, more here, and not as much here. I'm
8 really talking about the concern of this rapidly growing
9 population that might be negatively affected in whom we are
10 seeing a great rise in hospital and rehospitalization use.
11 So that's why I'm concerned about the rate. And I guess I
12 would -- 1.5 to 2.

13 MR. HACKBARTH: We are finishing round one.

14 MS. BEHROOZI: So the costs associated with
15 volunteers are the training and recruitment and all of that,
16 but you don't pay them for the work that they do, right?
17 But according to your paper, it says that hospices are
18 required to use volunteers to provide services to at least 5
19 percent of total paid patient care time. So the hospice
20 gets paid for the work that volunteers do? Is that what
21 that means?

22 MS. NEUMAN: So the hospice gets a per diem

1 payment regardless of what services are provided on a day,
2 and the hospice is required to use volunteers to provide
3 services or to do functions that amount to in a time
4 perspective equal to 5 percent of the paid time that they
5 expend in providing services.

6 MS. BEHROOZI: Right, but it's not like the
7 bereavement services that the hospice is not otherwise
8 compensated for, right?

9 MS. NEUMAN: Right. I mean --

10 MS. BEHROOZI: It's the services encompassed
11 within the per diem.

12 MS. NEUMAN: Yes.

13 MS. BEHROOZI: Are there any limitations on the
14 type of work that volunteers can do?

15 MS. NEUMAN: They don't count for things like
16 fundraising. It either has to be direct patient care or --
17 and I'll get back to you on the specifics, but I feel like
18 there is some administrative things that they can do. But
19 like fundraising and things like that, that's a no. That
20 doesn't count.

21 MS. BEHROOZI: But they can do patient care.

22 MS. NEUMAN: Like visiting a patient, yeah, yeah.

1 MS. BEHROOZI: Could you have a nurse volunteer?

2 MS. NEUMAN: Hospices do have some nurse
3 volunteers, physician volunteers, yes.

4 MS. BEHROOZI: And it says at least 5 percent of
5 the time. Is there any limit?

6 MS. NEUMAN: Not that I'm aware of.

7 MS. BEHROOZI: And does this distinguish between
8 for-profit and not-for-profit agencies?

9 MS. NEUMAN: As far as the rule or --

10 MS. BEHROOZI: Yeah.

11 MS. NEUMAN: No.

12 MS. BEHROOZI: I just have to say that that seems
13 very weird to me. This is a round two question, but, you
14 know, you're talking about profit-making entities making
15 their income based on people not getting paid. Aren't there
16 laws about that? Oh, I'm a labor lawyer, yeah. I think
17 there are. Maybe we could talk off-line a little bit about
18 whether there are some kind of protections or exemptions or
19 something. That's very strange to me, especially when you
20 see the margins, the extreme margins in some cases, of for-
21 profit agencies using, you know, unpaid labor. It's kind of
22 weird.

1 MR. HACKBARTH: It is anomalous, and I think part
2 of the reason that we got to this place -- correct me if I'm
3 wrong, Kim -- is I think the volunteer piece has been in
4 since 1983 when this was overwhelmingly a not-for-profit
5 enterprise.

6 MS. BEHROOZI: Yeah, I get, you know, the
7 admission-driven --

8 MR. HACKBARTH: And we just haven't changed
9 anything despite the fact that now it has become a largely
10 for-profit enterprise.

11 MS. BEHROOZI: Yeah, so I would really encourage
12 that we put that at the top of the list for policy
13 modification.

14 MR. HACKBARTH: Okay, round two, and please be
15 economical in your comments.

16 DR. BORMAN: I'm generally in a comfort zone with
17 this recommendation. I have one question, Kim. What
18 percentage of this market is Medicare? Could you remind of
19 the ballpark?

20 MS. NEUMAN: It's like the high 80s.

21 DR. BORMAN: Okay. I think that there are any
22 number of unknowns here. Particularly, we've spent a lot of

1 time in the past trying to make some comprehensive comments
2 about this, which the Congress in its wisdom will consider
3 whether to do or not. Making our best educated guesses
4 about the factors, I think we're in a landing zone that is
5 reasonable.

6 MR. ARMSTRONG: I agree. I would just say, as
7 reflected by several of the comments I, too feel like I have
8 two points of view on this. On the one hand, I'm working
9 very hard in a system that looks at the overall cost of care
10 and health outcomes, and we're investing like crazy in more
11 and more hospice services right now because there's a great
12 return on investment in that. And I think the Medicare
13 program is well served through what we spend on hospice.

14 On the other hand, in the context of the specific
15 rate decision that we're making right now, these are strong
16 margins relative to margins being made by other sectors in
17 the Medicare program. And I think closer to 1 percent than
18 1.5 percent is not going to slow the growth of hospice
19 services.

20 MS. HANSEN: I would just affirm what Scott said.

21 DR. CASTELLANOS: I second that.

22 DR. BAICKER: Agreed.

1 DR. STUART: [off microphone].

2 DR. KANE: I agree, and I also wonder if we can't
3 have the difference attributed to offset the SGR.

4 MR. KUHN: I'm fine with that range of discussion.

5 DR. BERENSON: So everybody's freed up a little
6 time for me to tell --

7 [Laughter.]

8 DR. BERENSON: I know it's late in the afternoon,
9 but sometimes an anecdote is so perfect that you got to do
10 it. I will be very fast on this one, I promise.

11 A couple weeks ago, I was at a social event and
12 met a woman who knew me as a doctor who did health policy.
13 She said, "I have something I just have to tell somebody.
14 Who should I tell about this?" She proceeded to tell me
15 that her mother, 95-year-old mother who had been in a life
16 care community for a number of years, about 15 months before
17 we were talking had been transferred to what she called
18 skilled nursing and I interpreted it as assisted living
19 within that facility. And at that moment, her hospice
20 benefit kicked in, and she said, "It's nice to have these
21 folks coming by, but it's perfectly redundant care." I
22 don't know what they're doing that she's not getting with

1 her \$6,000-a-month payment to the assisted living. And she
2 thought it was a terrible waste, but basically she wasn't
3 out-of-pocket anything and just thought as a good citizen
4 she should tell somebody. I told her I thought she had told
5 somebody who might have something to be able to do about it.

6 I guess two points I want to make. One, I think
7 we do really want to -- I mean, we've said it before, but I
8 think there is a real issue about nursing home/assisted
9 living being places where there may be inappropriate use of
10 hospice and sort of relationships established that are
11 generating referrals. She was in her 15th month, and she
12 said, "I have no reason to believe my mother's going to die
13 anytime soon. She's got dementia. That's the reason she's
14 in assisted living. But she's not declining in particular.
15 She's just getting her hospice benefit into her 15th month."

16 And the second thing, tomorrow we're going to be
17 talking about home health co-payments, and I think a similar
18 argument could be made here. I mean, she basically said
19 that, "If I were paying for anything, I probably would have
20 been doing something sooner than this. But, you know, it
21 doesn't affect my mother's payment. I'm just doing this as
22 a Good Samaritan, basically trying to find out who I should

1 talk to."

2 So I don't think we're do anything definitive on
3 the home health tomorrow on the co-payment, but I think when
4 we consider rationalizing cost sharing across the program,
5 I'd consider hospice with home health as two places that
6 maybe should have some form of co-payment -- not large co-
7 payment but something that gives everybody -- I won't use
8 the term "skin in the game."

9 MR. GEORGE MILLER: Yeah, in principle, I agree
10 with what Scott said and everybody around there, until I
11 heard Bob's anecdote. And I guess I got to reflect on the
12 hospital outpatient margins about a negative 10 percent, and
13 we gave them a 1-percent update. The hospice margins are
14 10, 11 percent for for-profits. They're the reason for the
15 major growth from \$2 billion to \$12 billion recently. They
16 had the length-of-stay problem. They had the issue that Bob
17 just brought up. I'm not even so sure that I'm going to
18 agree with even the 1 percent, quite frankly, but in
19 principle, I'll agree with Scott.

20 MS. UCCELLO: Yeah, I agree with Scott, and I'd
21 probably lean more toward 1.

22 DR. CHERNEW: I think it's important when looking

1 at these margins to realize that many of the lower ones in
2 some of these groups have the indirect rate in. So other
3 things are being added in there that aren't necessarily the
4 direct costs of the hospice in ways. So that said, this is
5 a particularly labor-intensive procedure, so it's hard to
6 get some of the productivity gains. And I do agree that,
7 when done right, it can have some advantages in terms of the
8 efficiency of care.

9 All of that said, I guess I am closer to
10 Scott's/last George in where I would come out on the
11 recommendation, recognizing how important and valuable this
12 service is.

13 MR. BUTLER: That's where I am, too, but I'd just
14 one quick thing. I do feel it's probably the most
15 underutilized of all of the services in Medicare and
16 probably the most misutilized at the same time, and that's
17 kind of the dilemma.

18 DR. CHERNEW: Right.

19 MR. BUTLER: Misutilized and underutilized, and
20 how we can really target this so it lands in the right place
21 as a very, very important tool is something that I think we
22 can contribute to, because the staffing so far, I think, on

1 all of this has been really good, and I think we can make a
2 unique contribution.

3 DR. NAYLOR: First, I am looking at the not-for-
4 profit margin here, but I obviously could be persuaded by
5 this group. I'm new here, and I think that I'll pay
6 attention closely to what they said. And I'm heartened by
7 the fact that this will be a focal point, palliation and end
8 of life and hospice going forward. So I can land where you
9 are.

10 DR. DEAN: I guess as far as the update I tend to
11 have the same concerns that George and several others have
12 voiced. This is so difficult because here we have an
13 extremely valuable service that we fail to be able to
14 define. And, you know, the six-month criteria is just
15 totally arbitrary. It got pulled out of mid-air. It's hard
16 to quantify. It's hard to predict. And yet I think we
17 really need to give some serious thought to trying to
18 further clarify the eligibility criteria, although I don't
19 know -- I don't certainly have any better ideas, but, you
20 know, Bob's anecdote is very relevant. I just struggle with
21 it. It's an important -- I mean, the Gawande article I
22 think was a powerful statement about how valuable this is,

1 but at the same time it's clearly being misused.

2 MS. BEHROOZI: In the discussion about the ASC
3 recommendation, the level of the recommendation, I was
4 thinking that if we're not going to be using strict failures
5 or empirically derived numbers, we should instead use a
6 principle, and if that principle is 1 percent because of
7 some reason -- because we think 1 percent will help do
8 something to constrain overall costs, or maybe it's Nancy's
9 principle that it's not the most important thing anyway and
10 it seems not unfair -- so it's 1 percent unless -- unless
11 there's some good reason to make it more or there's some
12 good reason to make it less.

13 So I'd say 1 percent just, you know, to kind of
14 introduce some kind of consistency and something -- a tool
15 for us to use to aggregate ourselves around. But I would
16 say for hospice -- and I'm just thinking about this now, so
17 this is like a very preliminary thing. I think for-profits
18 should pay their workers.

19 [Laughter.]

20 MS. BEHROOZI: And that would, you know, compress
21 these margins a little bit and compress the spread between
22 the costs of the for-profits and not-for-profits. And I

1 don't know, you have to -- obviously not-for-profits should
2 pay their workers, too, but, you know, you can have some
3 different kinds of constraints around the nature of the
4 volunteering in a not-for-profit. But I don't see how you
5 do it in a for-profit, especially when you've got this
6 margin that's clearly being made off the backs of human
7 beings doing the work.

8 MR. HACKBARTH: Okay, Kim. Well done. Thank you.

9 As we transition to our last presentation of the
10 day on skilled nursing facilities, I think the point that
11 Mitra just made is well taken, and so one of the things that
12 we will do as we go back through review of the conversation
13 is look at that horizontal, you know, really emphasize the
14 horizontal approach and maybe decision rules of the sort
15 that Mitra suggests. I'm just thinking aloud about this.
16 But when you cut loose from the market basket-based
17 calculation, it does increase the importance and the focus
18 that you put on the horizontal and how we're treating the
19 different sectors equitably. So we will emphasize that as
20 we go through this, and then I'll talk to each of you about
21 it.

22 Okay, Carol. You are up.

1 DR. CARTER: I am. Okay. I want to just start
2 with a thumbnail sketch of the industry and remind you that
3 there are about just over 15,000 providers and about 1.6
4 million beneficiaries. That's about five percent of
5 beneficiaries use SNF services. Program spending in 2010
6 topped \$26 billion. And I wanted to remind you that most
7 SNFs are parts of nursing homes that furnish long-term care,
8 which is a service that Medicare does not cover. Medicare
9 makes up about 12 percent of facility days, but about 23
10 percent of their revenues. And Medicare pays for this
11 service on a per day basis. That's described in the paper.

12 We'll be using the same framework that we've been
13 using for the rest of the update discussions. I wanted to
14 point out that there's an appendix in this chapter. PPACA
15 required MedPAC to examine trends in Medicaid utilization,
16 spending, and financial performance for providers where
17 Medicaid is a large share of either revenues or services,
18 and so we've done that for this provider, and that
19 information -- I won't be going into it here, but if you
20 have questions, I can answer them.

21 Okay. In fiscal 2010, spending for SNF services
22 was over \$26 billion. That's the yellow line. Growth in

1 total spending slowed to about two percent between 2009 and
2 2010, and this, in part, reflects the beneficiary enrollment
3 in MA plans whose spending is not included, and also a small
4 decline in use. Increases in spending on a fee-for-service
5 basis -- that's the pink line -- were also lower, reflecting
6 a slowdown in the growth in the intensification of the
7 highest payment rehabilitation case-mix days.

8 Access appears stable for most beneficiaries. We
9 don't have direct measures of access but instead use several
10 indirect measures to gauge it. First, supply has been
11 steady, with a small increase in the providers since 2000.
12 About three-quarters of beneficiaries live in counties with
13 at least five providers, and less than one percent of
14 beneficiaries live in a county without a SNF. There has
15 been a steady growth in the number of bed days available.
16 These increased four percent between 2008 and 2009.
17 Occupancy rates declined slightly, indicating that there was
18 space to admit beneficiaries. There was a small decline in
19 covered days and admissions, reflecting lower hospital use,
20 and Jeff talked about that this morning.

21 Two indicators of use concern us. First, the
22 number of SNFs treating medically complex patients continues

1 to decline, even though provider supply is stable.

2 Second, racial minorities had lower admission
3 rates than whites, but longer stays. Differences in SNF use
4 is consistent with other studies that generally have found
5 that minorities were more likely to use home health care and
6 informal care and less likely to use institutional care.
7 Lower use rates may also reflect differences in
8 hospitalization rates for racial minorities, and that's
9 required for a covered service under Medicare. And finally,
10 the longer stays for racial minorities may also reflect
11 differences in patient comorbidities, which are not
12 reflected in those use rates.

13 The two trends in service use discussed in the
14 paper underline the importance of previous MedPAC
15 recommendations. First, as I just mentioned, fewer SNFs
16 admit medically complex patients. Revisions to the
17 classification system will make these patients more
18 financially attractive to SNFs. However, payments for non-
19 therapy ancillary services, and those are largely drugs and
20 respiratory therapy, continue to be tied to nursing
21 payments. MedPAC recommended creating a separate payment
22 for NTA services, and his still needs to be done.

1 A second trend is the continued intensification of
2 therapy services. MedPAC recommended replacing the current
3 therapy component with one that bases therapy payments on
4 patient characteristics. CMS has not acted on this.

5 Last, the SNF PPS is one of the few prospective
6 payment systems without an outlier policy. This change
7 requires Congressional action. CMS does not have the
8 authority to create an outlier policy.

9 Turning to quality, we use two measures to assess
10 the quality, risk-adjusted rates of community discharge and
11 potentially avoidable rehospitalizations for five
12 conditions. Here, we see a mixed story for SNF quality.
13 Since 2000, the community discharge rate -- that's the top
14 line -- has increased slightly, indicating improved quality,
15 while the rehospitalization rate is about the same. And
16 between 2007 and 2008, both measures were virtually
17 unchanged.

18 We looked at differences in quality measures by
19 race and found that the observed differences were not
20 statistically significant once other patient characteristics
21 and comorbidities were considered.

22 We do see quite a bit of variation in quality

1 measures across facilities, and here you can see the 10th
2 and the 90th percentile along with the medians. I should
3 point out that the 10th and 90th, these are large samples
4 and they each include over 1,200 facilities. So they're not
5 just small tails. There are a lot of facilities in each of
6 them.

7 You can see that the community discharge rates
8 vary by more than threefold and the rehospitalization rates
9 vary twofold. And over the next year, we plan to examine
10 policy options to lower the variation across facilities.

11 Turning to access to capital, because SNFs are
12 parts of larger nursing homes, we assessed the capital for
13 nursing homes. Lending to nursing homes has improved since
14 last year. Despite the condition of many State budgets and
15 the poor economy, this sector is fairly resilient. Even
16 though Medicare is a small share of most homes' revenues, it
17 is seen as a generous payer that homes rely on financially.
18 Medicare continues to be a preferred payer.

19 Comparing payments and costs, the aggregate
20 Medicare margin was 18.1 percent in 2009. This is for free-
21 standing facilities. This is the ninth year in a row that
22 aggregate margins were above ten percent. There continues

1 to be variation in the financial performance across location
2 and ownership. Rural facilities had slightly higher margins
3 than their urban counterparts, and for-profit facilities
4 continued to have considerably higher margins than
5 nonprofits, though the difference was smaller this year than
6 in previous years.

7 Here's a snapshot of the distribution. About half
8 of freestanding SNFs had margins at or above 18.7 percent.
9 One-quarter of SNFs had margins at or below 8.8 percent,
10 while one-quarter had margins over 26 percent. About 14
11 percent of facilities had negative margins, and this was a
12 smaller share than in 2008. The most rural of SNFs, those
13 in areas with populations under 2,500 and not adjacent to a
14 metro area, had higher-than-average margins.

15 Not shown in this table, hospital-based facilities
16 continue to have very negative margins, negative 66 percent.
17 We have discussed in previous years the reasons for these
18 large differences in per day costs between hospital-based
19 and freestanding, including their higher staffing levels and
20 the fact that physicians appear to treat SNFs as extensions
21 of their inpatient stays. These factors result in much
22 higher routine and ancillary costs per day.

1 Our recommendations to revise the PPS would
2 redirect payments from freestanding facilities to hospital-
3 based facilities based on the mix of patients that they
4 treat.

5 To provide some context for the margins, we
6 compared freestanding SNFs in the top and bottom quartile of
7 Medicare margins. We find the cost differences were much
8 larger than the differences in revenues. Low-margin SNFs
9 had costs per day that were 41 percent higher, in part
10 explained by their lower average daily census and their
11 shorter stays over which to spread their fixed costs. On
12 the revenue side, low-margin SNFs had payments that were
13 seven percent lower than high-margin SNFs, reflecting a
14 smaller share of the more profitable therapy days. Low-
15 margin SNFs also had smaller Medicare shares of days.

16 We also looked at the performance of relatively
17 efficient SNFs, and like Jeff presented this morning, we
18 looked at -- we used both cost and quality measures to
19 define these. And like the definitions they use in the
20 hospitals, SNFs had to be in the top third for one measure
21 and not in the bottom third for any measure for three years
22 in a row. So they had to have consistent performance both

1 on quality and cost measures. And nine percent of SNFs, and
2 that was about 800 facilities, met these criteria.

3 Comparing the efficient SNFs to others, we found
4 that they had costs per day that were nine percent lower
5 after adjusting for differences in case-mix and wages,
6 community discharge rates that were 29 percent higher, and
7 rehospitalization rates that were 16 percent lower, and they
8 had higher margins.

9 Looking at trends since 2000, although efficient
10 SNFs made up nine percent of the study sample, they made up
11 11 percent of facilities with low-cost growth and of the
12 facilities with high-revenue growth. It is clear that it is
13 possible to furnish relatively low-cost, high-quality care
14 and do very well financially.

15 We project the SNF margin for freestanding
16 facilities to be 10.9 percent in 2011. The margin goes down
17 because payments were reduced in 2010 and 2011. In 2010,
18 payments were lowered to more accurately account for the
19 impact of the new case-mix groups that were implemented in
20 2006. In 2011, CMS reduced the update to account for a past
21 forecasting error.

22 In addition, SNF costs have been increasing faster

1 than the market basket. This projection assumed that costs
2 will increase at the actual average cost growth over the
3 past five years. This may be a conservative assumption
4 because cost growth may slow due to broad economic
5 conditions. And we did not factor in any behavioral
6 changes, such as shifts in case-mix that could change
7 payments.

8 In summary, the factors indicate that payments are
9 adequate, access and quality are stable, capital is
10 available, the Medicare margin was 18.1 percent in 2009, and
11 the projected margin for 2011 is 10.9 percent.

12 In 2012, the current law calls for payments to be
13 updated by a combination of the market basket increase and
14 the productivity adjustment as required by PPACA. The
15 market basket for SNFs is projected to be 2.6 percent and
16 the productivity adjustment is 1.3 percent. So net payments
17 are slated to increase by 1.3 percent.

18 The high aggregate margins indicate that Medicare
19 payments are high enough to accommodate a zero update, and
20 here is the Chairman's draft recommendation. It reads, "The
21 Congress should eliminate the update to payment rates for
22 skilled nursing facilities for fiscal year 2012." This

1 recommendation would lower program spending relative to
2 current law and it is not expected to impact beneficiaries
3 or providers' willingness or ability to care for Medicare
4 beneficiaries.

5 The update is not the only tool to help improve
6 the accuracy and incentives of the payment system. Past
7 recommendations have sought to improve the payment system
8 and to increase the value of the program's purchases.
9 Related to the payment updates, MedPAC recommended revising
10 the SNF PPS to add a separate NTA component to base therapy
11 components on predicted patient care needs and to add an
12 outlier policy. MedPAC also recommended linking program
13 payments to beneficiary outcomes by establishing a quality
14 incentive payment policy, and PPACA requires the Secretary
15 to develop an implementation for value-based purchasing by
16 October 2011.

17 If implemented, the Commission's recommendations
18 would narrow the differences in financial performance across
19 facilities and we will be rerunning these recommendations in
20 the chapter. And with that, I look forward to your
21 discussion.

22 MR. HACKBARTH: Thank you, Carol.

1 Could I ask you to put up Slide 11, please? I
2 want to pick up with the theme where we just left off, that
3 being the importance of treating similar situations more or
4 less the same as we look across the various provider groups.

5 Now, when I first saw these numbers, Carol, they
6 surprised me how high they were. You know, for a number of
7 years now, we've had both SNF and home health with quite
8 high margins compared to all of the other provider groups in
9 Medicare. My recollection of the history -- and I may well
10 be wrong, and so please, if I am wrong, correct me. But my
11 recollection is that mostly the SNF margins have been in the
12 10-, 11-, 12-, 13-percent range, and home health have been
13 usually 4, 5, or 6 percent higher than that, up in the mid-
14 to high teens. And so both have been high, both have been
15 double digits for a long time, home health sort of a notch
16 higher than SNF.

17 And so when I saw the 18-plus percent -- 18.1 is
18 the median -- or 18 --

19 DR. CARTER: Yeah, 18.1 for an aggregate.

20 MR. HACKBARTH: Yeah, in the aggregate. Again, I
21 was surprised. That seemed higher than I remembered. So
22 let me stop there. Are these numbers higher than they have

1 been --

2 DR. CARTER: They are higher. Last year we
3 reported for 2008 it was 16.6, and the year before that it
4 was 14.7.

5 MR. HACKBARTH: Yeah, so they have been sort of
6 creeping higher.

7 DR. CARTER: They're creeping up, and they do
8 reflect the increasing share of case-mix days in the highest
9 payment groups.

10 MR. HACKBARTH: Right, right.

11 DR. CARTER: So something like 90 percent of days
12 are now rehab, and 70 percent of those are in the two
13 highest case-mix groups.

14 MR. HACKBARTH: Right, right. So here's where I'm
15 going with this. We recommended rebasing of the home health
16 system, which is another way of saying actually cutting the
17 rates. We have not gone to that point in the past with
18 skilled nursing. We've had zero update recommendations for
19 a large number of years now, but have never gone the
20 additional step of saying the rates ought to be rebased and
21 even lowered.

22 In my mind, part of the difference between the two

1 have been, A, that -- my recollection of the history was
2 that the home health margins were always somewhat higher,
3 but in addition to that, I've always been concerned about
4 the medically complex skilled nursing patient where we've
5 actually consistently said, you know, there are some
6 potential access problems for the medically complex skilled
7 nursing. And so the way my mind has worked on this is we
8 really needed to fix the case-mix problems that are in SNF
9 before going the additional step of potentially recommending
10 a rebasing. So that has sort of been where my mind has
11 been. But even with that, in my mind, when I saw 18-plus
12 percent is the median margin, I must say I was a little
13 taken aback. We've sort of jumped up there, it sounds like,
14 in two-percentage-points increments the last several years.

15 So there's not an answer at the end of that, but
16 in keeping with the earlier conversation about, you know,
17 being consistent across sectors, I wanted to offer that for
18 people to chew on.

19 I think we're starting on Mitra's side, so round
20 one clarifying comments?

21 MS. BEHROOZI: [off microphone].

22 MR. HACKBARTH: Okay. Tom? Mary? Peter? Mike?

1 Cori? I think you're tired.

2 [Laughter.]

3 MR. HACKBARTH: George isn't tired.

4 MR. GEORGE MILLER: No. I am. But you raised a
5 very good point. What would that rebasing look like?

6 Because I think you're right on point.

7 MR. HACKBARTH: You know, I don't have a rebasing
8 proposal to offer. What we have said in home health is that
9 they ought to go back and look at the average cost -- the
10 product has changed -- and rebase the rates on up-to-date
11 costs as opposed to old patterns of care. How it would be
12 done in SNF I have not even begun to think about.

13 MR. GEORGE MILLER: But one point that you brought
14 up, if I remember correctly from the presentation, and the
15 medically complex patients have gone down, so that's even,
16 it seems to me, more of a reason. I don't know where those
17 patients are --

18 MR. HACKBARTH: What do you mean when you say
19 they've come down?

20 MR. GEORGE MILLER: Fewer medically complex
21 patients. They're treating fewer. Do I have that correct?

22 DR. CARTER: No. What I said was there were fewer

1 SNFs treating them, so they're increasingly concentrated at
2 the SNFs that do treat them.

3 MR. GEORGE MILLER: Okay. All right.

4 MR. HACKBARTH: So the number of patients isn't
5 shrinking.

6 MR. GEORGE MILLER: Right.

7 MR. HACKBARTH: It's just they're more
8 concentrated, which incidentally, to the extent that that's
9 true and you don't have an appropriate payment system for
10 them, and if they're concentrated in a few facilities and
11 you rebase, those people who've been picking up the slack in
12 the system, as it were, and caring for the really difficult
13 patients really get whacked.

14 DR. CARTER: I would want to just put a couple
15 more pieces of information -- and it's in your chapter. The
16 revisions to the case-mix groups that CMS plans to implement
17 with RUGs-IV really is going to make a big difference for
18 both expanding the number of groups for medically complex
19 cases but also redirects money towards medically complex
20 patients because of the way it moved money from the therapy
21 component to the nursing component.

22 MR. HACKBARTH: This is probably a question that

1 is unanswerable, but my impression has been that we've said
2 to CMS, oh, this is a step in the right direction, the
3 changes that they've made, but you've not gone far enough.
4 And so we keep insisting there needs to be a separate non-
5 therapy ancillary payment and, you know, get away from the
6 therapy-based payments.

7 So if they've gone in the right direction but not
8 far enough, how much of the distance in the right direction
9 have they gone with these changes? How much are they
10 improving the situation for the medically complex?

11 DR. CARTER: Well, we can't model that because we
12 can't -- there aren't the data to replicate the new
13 classification group, so that has been the problem;
14 otherwise, we would have modeled that. I think they will
15 make a big difference, but I don't know how much.

16 MR. HACKBARTH: Okay.

17 DR. BERENSON: I was going to be asking -- I want
18 to pursue this just a little more. When I was at CMS, I
19 visited a SNF that basically only did very complex patients,
20 and I guess my first question is: When you say they tend to
21 be concentrated, are there SNFs that don't have long-term
22 residents that only do skilled nursing for that period of

1 time?

2 DR. CARTER: Certainly hospital-based tended --

3 DR. BERENSON: Hospital-based, yeah, by definition
4 would.

5 DR. CARTER: I don't know. I haven't looked at
6 that, so I'm not sure.

7 DR. BERENSON: And do we know if some of those
8 kinds of SNFs are LTCs, also? Can they be both?

9 DR. CARTER: I don't think they can be both.

10 DR. BERENSON: Okay. So they can be one or the
11 other.

12 DR. CARTER: Right.

13 DR. MARK MILLER: I think on that there may be a
14 couple of exceptions, but generally no.

15 DR. BERENSON: But the patient population is often
16 similar, right?

17 DR. MARK MILLER: See, you said this in passing,
18 but I wanted to kind of track on it. You said long-term
19 residents.

20 DR. BERENSON: I was talking about a long --
21 nursing home patients, you know.

22 DR. CARTER: So like a ventilator patient that

1 might be, right.

2 DR. BERENSON: I'm talking about ventilator
3 patients, is who I'm talking --

4 DR. MARK MILLER: And I just want to quickly
5 delineate a couple of things. So long-term-care hospitals,
6 I mean, one of the requirements is -- we'll talk about this
7 tomorrow -- a 25-day length of stay, and so that tends to be
8 people who are in for a long period of time. Then you have
9 the nursing facility which you can -- and I'm sure I'm not
10 doing it justice, but think of it as two ways. There is the
11 residential beneficiaries there and then this group, the
12 skilled nursing facility, which tends to be shorter stay.

13 DR. CARTER: The average length of stay is about
14 23 days.

15 MR. KUHN: One thing, Carol, just to make sure I
16 heard you right. In the current RUGs, 54 RUGs, there's nine
17 that are therapy RUGs, correct? Or rehab --

18 DR. CARTER: You're thinking about -- there are
19 nine -- the new rehab plus extensive services.

20 MR. KUHN: Right.

21 DR. CARTER: There are many more rehab --

22 MR. KUHN: Right, there's three that are the

1 rehab, but you said of those RUGs right now that -- what
2 were the percentages that were falling in kind of those
3 upper reaches of those RUGs? Can you just say that one more
4 time?

5 DR. CARTER: About 92 percent of all days are
6 classified into a rehab RUG, and of those, about 70 percent
7 are in the ultra high and very high.

8 MR. KUHN: Okay, thanks. And the other quick
9 thing, in the chapter I noticed there was the appendix that
10 talked about that new section of PPACA that asks us to look
11 at Medicaid utilization. Under the statutory reading, this
12 would satisfy the needs for our requirements under the law,
13 this appendix in our annual chapter. Is that our
14 understanding?

15 DR. MARK MILLER: That is our understanding, and
16 what we're doing is trying -- I'm trying not to laugh as I'm
17 giving --

18 [Laughter.]

19 DR. MARK MILLER: We're trying to meet the
20 statutory requirement; you know, we're starting here with
21 skilled nursing facility to try and work up the data as best
22 as we can. There may be some other areas that we'll add as

1 we go. We are trying to meet it, and, yes, that is our
2 attempt to take the first step in that direction.

3 DR. KANE: My only question is: If you
4 redistribute this more toward the medically more complex,
5 the aggregate margin would still be 18 percent, or not? I'm
6 just trying to figure out what a redistribution towards --

7 DR. MARK MILLER: Yeah [off microphone].

8 DR. KANE: So you would still have an aggregate at
9 18 percent because the revenue and the costs are still
10 aggregate.

11 DR. CHERNEW: [off microphone] Unless they change
12 behavior.

13 DR. KANE: Yes, right. Unless they change
14 behavior in what way? Like --

15 DR. CHERNEW: [off microphone] more or less
16 profitable.

17 DR. KANE: Yeah, toward more or less --

18 DR. CHERNEW: If you make one group relatively
19 more profitable or not and they move around, the costs and
20 the revenues would change.

21 DR. KANE: Yes, but it's kind of hard to know --
22 yeah, right.

1 DR. CHERNEW: Yes, it is.

2 DR. KANE: Yes, okay. That was my question.

3 That's what's built in right now, and a new case-mix system
4 will just redistribute but -- and assuming not a big
5 behavioral change.

6 DR. STUART: Yeah, I'm curious in terms of how
7 well we were able to predict margins back in 2007 and 2008.
8 Did we predict that margins would go up even with a zero
9 update?

10 DR. CARTER: You know, we've never tried to model
11 a behavioral reaction.

12 DR. STUART: But that's what I'm wondering,
13 because we're projecting that the margins for 2011 are going
14 to drop to 10.9 percent. Now, that's a huge drop from 18.7.
15 But maybe there's this behavioral thing in there, and then
16 next year it will be 19.8 percent.

17 MR. HACKBARTH: Just a point of clarification. We
18 have been recommending zero updates for a long time, but
19 that's not what skilled nursing facilities have gotten
20 historically.

21 DR. CARTER: No, they've been getting, you know,
22 market basket minus sometimes --

1 MR. HACKBARTH: Yeah, so this growth in margins
2 that Carol described going up a couple percentage points is
3 not in a zero update environment.

4 DR. STUART: The question remains about how well
5 we are able to project what the margin would be given an
6 update, and if there is a strong behavioral response and
7 it's a negative response from the standpoint of access to
8 care, particularly for the kind of person that you would
9 think would need this kind of service, then I think that's
10 something that we should take into consideration.

11 MS. HANSEN: Well, yes, it's not a question but a
12 quick comment. Just again affirm how we assure this, the
13 access to complex patients. So if the new RUGs system will
14 perhaps provide sufficient incentives for that, that's
15 great. The concentration in certain places, on the one hand
16 I can really understand from an operational standpoint
17 because then you'll have more competently prepared people
18 maybe focused to do that. But as the volume grows, I think
19 as Mary has pointed out, in terms of population, just, you
20 know, assuring that other facilities will be available to do
21 this in a more distributive basis.

22 MR. HACKBARTH: On to round two [off microphone].

1 MS. BEHROOZI: Yeah, I like taking a deeper look
2 than just the payment update, as you suggested.

3 MR. HACKBARTH: So you are saying that you would
4 be open to going below zero?

5 MS. BEHROOZI: In the result, yes, but doing it in
6 an intelligent way that addresses some of the -- I mean,
7 we've made recommendations. I don't know if they were all
8 adopted whether it would address all of the issues since we
9 have seen margins growing. But, yeah, margins -- I mean, in
10 two years it sounds like margins at the median increased by
11 four points over 14 points, which is a lot in two years.

12 MR. HACKBARTH: Right, right.

13 MS. BEHROOZI: That's close to 30 percent, or
14 whatever.

15 MR. HACKBARTH: I don't want to create
16 expectations or fears in the audience that may not come to
17 pass. I'm surprising Carol and Mark in talking about
18 rebasing, but this is just something that comes to me as --
19 you know, I've listened to the discussion all day long and
20 the emphasis on, you know, equity, and so an obvious
21 question is, Why are we rebasing home health and not these
22 folks?

1 DR. KANE: In home health, I recall an exhibit
2 that actually showed the percentage of nursing and therapy
3 and aide visits back whenever it was -- 1998 -- was very
4 different than what is now being visible. But it's hard to
5 tell what's different here in terms of the inputs. There
6 were very different inputs.

7 MR. HACKBARTH: Yeah, excellent point. That is
8 one of the distinctive characteristics of home health. And
9 as I said earlier, part of my own thinking about this has
10 been that you wouldn't want to do rebasing given our
11 concerns about access to care for medically complex until we
12 felt like the case-mix system had been sufficiently
13 improved.

14 So, again, you know, let me talk to Mark and Bob
15 and Carol about this, and then I'll talk to each of you
16 after that. Tom, any thoughts to offer?

17 DR. DEAN: No. I'm comfortable with where we're
18 at [off microphone].

19 DR. NAYLOR: As am I.

20 MR. BUTLER: I am okay, too, but I do have an
21 overnight assignment for you because I like your episodes of
22 care so much. I just had a thought, though. This will just

1 take a second. As we look at all these -- it helps me
2 integrate the day, too. If you take a look at all these
3 silos, particularly all the post-acute, if you had the
4 aggregate dollars at the bottom and you had all of the
5 diseases that we're treating in Medicare, whether it's
6 episodes or the -- and you could look at where all of our
7 dollars are being spent, it would give an interesting
8 profile of the trade-offs between these various post-acute
9 sectors that would kind of give a scorecard that we could
10 kind of say, oh, that's where we're spending the dollars to
11 treat neurological diseases or congestive heart failure or
12 whatever it is. It might be a nice analytical tool, so when
13 we have the trade-offs between rehab versus home health
14 versus hospice, it might help some of our thinking. But you
15 don't have to do it overnight, but in the future.

16 [Laughter.]

17 MR. HACKBARTH: Yeah, this is important [off
18 microphone] look at the data in different ways, for example,
19 on a disease basis as opposed to by --

20 DR. CHERNEW: And, I mean, our push for
21 productivity would involve substituting appropriately across
22 these settings, and that's really hard to encourage in this

1 silo-based exercise that we march through every winter, and
2 it really emphasizes the lack of integrated policy.

3 I guess there's just two things I wanted to say
4 before my quick comments on the recommendation. The first
5 one is these are Medicare margins, and there's a huge cross-
6 subsidy. And I know that Glenn has said our job is not to
7 subsidize Medicaid, and I agree with Glenn's point that our
8 job is not to subsidize Medicaid. But I think that we do
9 care about access of the beneficiaries, and so we just have
10 to be cognizant of the connections, whether we want to or
11 not. And given the fiscal situations that the states face,
12 if we do this all based on just Medicare, we might be
13 ideologically pure, which won't really be worth a lot to the
14 beneficiaries who face problems. So I worry a lot about
15 that, just as sort of a sleep-at-night kind of thing.

16 Secondly, I think we want to move to this sort of
17 long-term care bundling thing, and there's going to be
18 hopefully a lot of demonstrations, not just about looking at
19 it episode-wise, but changing the related incentives. And
20 that will affect how all of this plays out. And so Bob made
21 a point in a previous meeting about fee-for-service in
22 general and how the rates will be set. And so when we make

1 our recommendations now for a number of these things, we're
2 not just making recommendations in the fee-for-service
3 system going forward, but it has ramifications for how
4 things like bundled -- the level that bundled payments would
5 be at and stuff, and we need to think through that and the
6 ramifications of that.

7 So the bottom line is I'm comfortable with the
8 recommendation as given. I'm open to the idea of doing
9 something more. But if you're going to do something more, I
10 think it has to be done in this broader context of
11 integration, a cross-subsidy, and the states' Medicaid stuff
12 and all of those things. So it's actually, I think, harder
13 to do -- I might say this again when we get to home care,
14 incidentally, but I think it might be harder to do than it
15 otherwise might have been given all of the complicated
16 moving pieces in this area that's fraught with difficulty.

17 MS. UCCELLO: I'd agree with that.

18 DR. BERENSON: Yeah, I'll agree with that.

19 MR. KUHN: I'm fine [off microphone].

20 DR. KANE: I'd believe in anything to get up and
21 go home.

22 [Laughter.]

1 DR. KANE: But I guess my only thought was -- and
2 I know this is just too complicated, but I am worried a
3 little bit about the high Medicaid places where the Medicare
4 is holding them up. But I'm wondering how hard it would be
5 -- since I see we have total margins, we must have total
6 revenues -- to look at these margins in relationship to the
7 percentage of the total business that's Medicare. And then
8 I don't know if we have Medicaid, but it just would be
9 interesting to see if that's the case, that the high
10 Medicaid places have the highest Medicare margins or not. I
11 don't know if that's truly -- if the high Medicaid places
12 are the places where there's really high Medicare margins,
13 then you'd worry about cutting the Medicare margin. But if
14 the high Medicaid places have relatively low Medicare
15 margins, you're not doing that much more damage to them than
16 they already have done to themselves.

17 MR. HACKBARTH: In addition to that --

18 DR. KANE: Does that make sense?

19 MR. HACKBARTH: I think so. But the other way of
20 looking at this which I have tended to emphasize is that
21 using Medicare rates, high Medicare rates to subsidize low
22 Medicaid rates is problematic because the nursing homes that

1 need the money most are the ones with high Medicaid shares
2 and low Medicare shares.

3 DR. KANE: And that's why I want to see if the
4 margins correlate to that at all. I don't know.

5 DR. STUART: The only thing that I would add to
6 the cross-subsidy issue is that it's really quite different
7 than when we're talking about hospital payment Medicare
8 margins being negative and being offset by private-pay
9 patients. The Medicaid patients are also Medicare, and so
10 trying to figure out what's going to happen to the same
11 patient -- I mean, not during the same stay, obviously, but
12 it's very common for Medicare patients to stay beyond the
13 SNF stay and then become, you know, ultimately Medicaid
14 patients. So I would just add that caution in here in terms
15 of trying to understand what the implications of that are.
16 Otherwise, I support the proposal.

17 DR. BAICKER: I support it, and I liked Mitra's
18 framing of things as starting with a basic default of
19 something like 1 percent and justifying based on
20 observations like this.

21 DR. CASTELLANOS: [off microphone] I agree.

22 MS. HANSEN: I agree, but with a question. It

1 just struck me, something that Bruce just said. I just
2 wonder how many of the people who end up being Medicaid
3 start off as Medicare. So, in other words, they start off a
4 private-pay or post-acute and then they end up custodially
5 staying for a long time and then ending up Medicaid. And
6 how often does that happen? So just if you know that.

7 MR. ARMSTRONG: So I agree that in this section
8 we're overpaying for what we're getting, and that to -- the
9 recommendation is to hold payment flat. I think we should
10 consider some kind of rebasing. I don't really fully
11 appreciate the implications of that.

12 To this whole point about, you know, there are
13 boundaries that get broken between Medicare and other payers
14 and margins and so forth, it happens in all of these
15 different sectors. I think we're here in one sector where I
16 think we're generally believing we're paying more than we
17 should be. But if that's the case, then I wouldn't use the
18 overpayment to subsidize Medicaid programs necessarily. I
19 think we should consider whether we should be subsidizing
20 other parts of the Medicare program as an alternative. And
21 so I don't know what you do with that.

22 Also, just to Peter's point earlier, you know, at

1 the end of the morning tomorrow it will be very interesting
2 to have a chance just to talk a little bit about how this
3 along with some of the other sectors really get all kind
4 intermingled in some of our work going forward after January
5 to look at some kind of bundling or other reform ideas that
6 just might make some of these silo decisions a little bit
7 more sensible.

8 DR. BORMAN: Intellectually, I'm fine with where
9 we are now. I have a little bit of Mike's visceral reaction
10 of concern.

11 MR. HACKBARTH: Let's see here. 5:50. We made up
12 some ground. So now we'll have our public comment period.

13 Seeing none, we are -- oh, Marianne.

14 Is that on?

15 MS. LOVE: Sorry to be the person who keeps you
16 here late.

17 I appreciated your comments, Glenn, this morning
18 about trying to work towards harmonizing the updates for
19 settings that are providing the same service. I think from
20 the ASC setting perspective -- I'm sorry, I'm Marianne Love
21 from the ASC Association.

22 The savings to the Medicare program and the

1 efficiencies of the ASC setting are baked into the rate
2 differential already. Medicare is paying 44 percent less
3 for a service done in an ASC than in a hospital. So I think
4 moving towards a system that, on an annual basis, is
5 updating things at the same rate is a good step in the right
6 direction.

7 So we would actually like to see the Commission
8 move towards an affirmative recommendation that is
9 consistent with the hospital outpatient recommendation.

10 We think the slightly higher recommendation than
11 what you discussed earlier today is warranted. The data
12 that you're looking at for 2009 is the second year of a new
13 payment system in which rates for many common ASC services
14 are being substantially reduced. We know that 2010 is on
15 track to be the lowest growth rate of ASCs probably in the
16 history of the program for the ASC payment setting. And the
17 largest public operators of ASCs are reporting flat or
18 negative same store growth for their centers, Medicare and
19 commercial.

20 These things, I think, are all important signals
21 that should be considered. One of the things that we're
22 seeing is an increasing number of hospitals buying ASCs,

1 buying out the physician owners, converting those ASCs to
2 the hospital license. This comes at great expense to the
3 Medicare program and the taxpayers that support it.

4 So we think an affirmative update recommendation
5 sends a very strong and positive signal to the industry that
6 they'll be on stable ground going forward and continue to
7 provide those savings to the program.

8 Thank you.

9 MR. HACKBARTH: Okay, we are adjourned until 8:15
10 tomorrow morning.

11 [Whereupon, at 5:53 p.m., the meeting was
12 recessed, to reconvene at 8:15 a.m. on Friday, December 3,
13 2010.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 3, 2010
8:17 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [8:17 a.m.]

2 MR. HACKBARTH: Okay. Good morning. So this
3 morning, we continue our discussion of our update
4 recommendations for fiscal year 2012. We have three
5 presentations today.

6 For those of you in the audience who were not here
7 yesterday, yesterday and today, we are discussing draft
8 recommendations for updates for each of the provider groups
9 serving Medicare beneficiaries. These are draft
10 recommendations that I have prepared and am offering to the
11 Commission for discussion. We will have final votes on
12 recommendations at the January meeting. The final
13 recommendations that we vote on may be the same as the draft
14 or they may be modified as a result of the conversations
15 that we've had yesterday and today.

16 Since the last time we did update recommendations
17 a year ago, obviously, there's been a major legislative
18 change in PPACA. Among other things, what it did was
19 establish a new budgetary baseline for all of the updates.
20 Obviously, that's very important. However, the task that
21 we've been assigned by the Congress is to provide our best
22 assessment year by year on the level of payment that is

1 appropriate for the efficient delivery of services in a
2 given provider group, a level of payment that will assure
3 adequate access to high-quality care for Medicare
4 beneficiaries by efficiently managed organizations. So,
5 obviously, the recommendations we make could be different
6 than what is in current law, and if it's higher, that would
7 entail a budgetary cost. If it's lower, it would be a
8 savings.

9 As always, in talking about the update
10 recommendations, we use a multi-part framework. Where
11 available, one piece of that is information on financial
12 performance, on margins, but that's not the only part of the
13 framework. Other considerations are access for patients and
14 what's happening there, access to capital for the
15 organizations, and the like.

16 Anything else?

17 DR. MARK MILLER: [Off microphone.] Updates and
18 distribution under --

19 MR. HACKBARTH: Oh, yes. Another critical piece
20 is as we conceive of the update process, the update simply
21 establishes the size of the pool of dollars available for a
22 particular provider group. Often, there are important

1 issues about how that pool of dollars, whatever it might be,
2 are distributed and whether the money is distributed in a
3 way that is fair, equitable, and rewards effective,
4 efficient delivery of care, and so sometimes, not for every
5 provider group, but sometimes in addition to making an
6 update recommendation, we will also make a recommendation
7 about the distribution of those dollars, and in fact, when
8 we proceed with the home health presentation discussion,
9 there are issues about how the existing case-mix system
10 distributes the dollars.

11 So with that as background, let me turn it over to
12 Evan for the home health presentation.

13 MR. CHRISTMAN: Good morning. Today, we are going
14 to cover the payment framework as it pertains to home
15 health. We will also review draft recommendations that
16 provide policy options to improve payment accuracy,
17 strengthen patient safeguards, establish beneficiary
18 incentives, and advance program integrity.

19 I am going to start with the framework. As in
20 previous years, the supply of providers and access to home
21 health continues to increase. Ninety-nine percent of
22 beneficiaries live in an area served by one home health

1 agency. Sixty percent live in an area served by ten or
2 more. While there are some areas that lack home health
3 agencies, they are relatively few in number. Our measure of
4 access is based on ZIP code-level data which tracks the
5 areas served by a home health agency in the last year. This
6 data may overstate access for some areas because agencies
7 need not serve the entire ZIP code to be counted as serving
8 it. On the other hand, the data may understate access if
9 agencies are willing to serve a given ZIP but did not
10 receive any requests from those areas.

11 Turning from access to supply, the number of
12 agencies was over 11,300 by the end of 2010, a number that
13 exceeds the peak level of supply reached in the 1990s when
14 Congress significantly changed the benefit to address fraud
15 and problematic payment incentives. The growth in 2010 is
16 consistent with prior years. For example, over 1,000
17 agencies entered the program in 2009. And while the growth
18 has been significant, for the last few years, it has been
19 concentrated primarily in Texas and Florida.

20 Next, we look at volume. Use of the benefit has
21 increased significantly in the last seven years. The number
22 of users has increased to 3.3 million in 2009, or over nine

1 percent of fee-for-service beneficiaries. The number of
2 episodes has risen to 6.6 million in 2009, a growth of more
3 than 50 percent since 2002. The episodes per user has also
4 increased, from 1.6 to two episodes per user in 2009,
5 implying that beneficiaries are staying on service for
6 longer periods.

7 The 50 percent rise in total episode volume has
8 been accompanied by an increase in episodes serving patients
9 admitted directly to home health from the community. In
10 2001, home health episodes were split about evenly between
11 patients admitted after a hospital or PAC stay and episodes
12 where the beneficiary was admitted directly from the
13 community. In the years since, episodes for community-
14 admitted patients have increased by over nine percent a
15 year, faster than the rate of growth for all episodes.
16 Because of this fast growth, in 2008, episodes for
17 community-admitted patients were about two-thirds of home
18 health episodes, and post-hospital or PAC episodes
19 represented only about 36 percent of episodes.

20 At the last meeting, some Commissioners asked
21 whether some of the growth in community-admitted patients
22 was due to beneficiaries using home health after receiving

1 outpatient surgery. Our review of outpatient surgery claims
2 suggested this was not a major factor, as about 4.5 percent
3 of community-admitted patients in 2001 had outpatient
4 surgery prior to home health and the share for 2008 is
5 slightly lower, at 4.3 percent.

6 Other shifts in volume which have occurred are
7 related to how CMS changed therapy payments in 2008. In
8 that year, CMS implemented a new system that dropped payment
9 for episodes in the ten to 13 therapy visit range and
10 increased it for episodes above and below this range. If
11 you look at the green bar of the middle graph, you will see
12 that a significant number of episodes were clustered in the
13 ten to 13 therapy visit range in 2007. In 2008, when
14 Medicare reduced its payments for these episodes, they
15 declined. The red bar in each part of this graph shows how
16 agencies reacted after this change in 2009. Visits
17 increased for the two groups with higher payment and
18 decreased for the group with lower payment.

19 The timing and nature of the change in episode
20 volume suggests that the use of therapy visits as a payment
21 factor may permit payment incentives to trump patient
22 characteristics in setting therapy plans of care. Later, we

1 will discuss a predictive approach that uses patient
2 characteristics to set therapy payment that would be less
3 prone to manipulation.

4 This next table shows risk-adjusted quality
5 measures for home health. For the first five measures, all
6 measures of a beneficiary's functioning, the steadily rising
7 line indicates there has been consistent increase in the
8 number of beneficiaries who improved. The bottom blue and
9 green lines show adverse events, such as hospital admissions
10 or the use of urgent care. A decline would indicate
11 improvement for these measures. However, the rate of
12 adverse events has not changed significantly.

13 Last year, the Commission expressed concern that
14 the current measures were too broad and did not necessarily
15 measure outcomes related to the need for skilled care. We
16 have launched a project to develop clinically-focused
17 measures and expect to report them when they are complete.

18 Next, we look at capital. It is worth noting that
19 home health agencies, even publicly-traded ones, are less
20 capital intensive than other health care providers. Also,
21 few are publicly traded. Financial analysts have concluded
22 that for those publicly-traded ones, they have adequate

1 access to capital, though because of the payment reductions
2 in the PPACA and several Federal investigations into
3 industry billing practices, the terms are not as favorable
4 as prior years. For agencies not part of publicly-traded
5 companies, the continuing entry of new agencies reflects
6 that smaller entities are able to get the capital they need
7 to expand. As I mentioned earlier, over 1,000 new agencies
8 entered Medicare in 2009, and so far, over 500 have entered
9 in 2010.

10 Next, we turn our attention to margins for 2009.
11 You can see that overall margins for freestanding providers
12 in 2009 are 17.7 percent. However, there is variation in
13 the margins. For example, the agency at the 25th percentile
14 had a margin of 2.2 percent while the agency at the 75th
15 percentile had a margin of over 26 percent. Margins for
16 providers that serve mostly urban patients were 17.9
17 percent, while they were 16.6 percent for agencies that
18 serve mostly rural patients. For-profit margins equal 18.7
19 percent. Nonprofit margins were 14.4 percent.

20 These numbers highlight two concerns that the
21 Commission has had for many years, that home health margins
22 have been excessive and that the wide variance in margins

1 may reflect inaccuracies in the case-mix.

2 I would note that we only report margins for
3 freestanding providers in this presentation. Hospital-based
4 providers, whose margins were included in those reported
5 during the review of hospital payments, averaged a margin of
6 negative-5.4 percent in 2009.

7 Since 2001, home health margins for freestanding
8 providers have averaged 17.5 percent. The high margins are
9 the result of at least two factors. The first factor is
10 that home health agency cost growth has been lower than the
11 payment update in most years. Because actual inflation has
12 been lower than market basket inflation, payment increases
13 have exceeded the growth in providers' costs.

14 The second factor is that the number of visits in
15 an episode has always been lower than what Medicare assumed
16 when it initially set home health rates. Medicare assumed
17 the average episode would include 32 visits, while under PPS
18 the average has been about 22 visits. As a result, Medicare
19 rates assumed more costs in the average episode than
20 providers actually incur.

21 We estimate margins of 14.5 percent in 2011. This
22 is the result of several payment and cost changes. Agencies

1 received a two percent update in 2010, offset by a 2.75
2 percent reduction for coding. In 2011, the PPACA reduced
3 the payment update to 1.2 percent and included a base rate
4 reduction of 2.5 percent. The PPACA also includes a three
5 percent rural add-on. And in addition, CMS reduced payments
6 by 3.89 percent in 2011 for changes in coding.

7 We expect case-mix to increase by another two
8 percent in 2010 and 2011 and assumed cost growth of one
9 percent in 2010 and a higher rate of 1.7 percent in 2011.

10 Here is a summary of our indicators.
11 Beneficiaries have good access to care in most areas. The
12 number of agencies continues to increase, reaching over
13 11,000 agencies in 2010. The number of episodes and rate of
14 use continues to rise. Quality shows improvement on most
15 measures. Access to capital is adequate. Margins for 2011
16 are projected to equal 14.5 percent. And margins, again,
17 for 2009 were 17.7 percent. These findings are very similar
18 to prior years.

19 Next, we will turn to recommendations. Before I
20 do that, let me remind Commissioners of changes in the PPACA
21 that have some relation to our draft payment adequacy
22 recommendation for 2012. Recall that in last year's March

1 report, we recommended that home health payments be rebased
2 to equal costs in 2011. The PPACA implements a phased
3 rebasing which begins in 2014 and is phased in over four
4 years. The reductions would be limited to no more than 3.5
5 percent a year, and this reduction would be offset each year
6 by the payment update. Given the positive indicators for
7 the industry, the delay seems unnecessary. In addition,
8 including the market basket update as an offset makes these
9 reductions similar and in some cases smaller than those that
10 industry has weathered in the past, so it would likely
11 result in agencies maintaining high margins.

12 Here is a draft recommendation for 2012. It calls
13 for an acceleration of the rebasing already in law and the
14 elimination of the market basket update. It reads, "The
15 Congress should direct the Secretary to begin a two-year
16 rebasing of home health rates in 2012 and eliminate the
17 market basket update for 2012." This would be a decrease
18 relative to current law, and in terms of beneficiary and
19 provider implications, we expect that some providers may
20 choose to withdraw from the program but that remaining
21 supply should be adequate to provide adequate access to
22 care.

1 In addition to concerns about high margins, there
2 has also been concern about the distribution of payments and
3 whether the payment system provides appropriate incentives.
4 First, as shown earlier, the inclusion of the therapy visits
5 as a factor in setting payments allows agencies to follow
6 financial incentives when determining the number of therapy
7 visits provided. In addition, a review of the payment
8 system indicates that it overpays for high case-mix
9 episodes, which are predominately therapy, and underpaid for
10 low case-mix episodes. For example, in a review of data
11 from 2007, high-margin agencies had a case-mix that was
12 seven percent higher than low-margin agencies.

13 An analysis by the Urban Institute found that the
14 current system is highly dependent on the use of therapy as
15 a predictor for its accuracy. With therapy as a predictor,
16 the system could explain 55 percent of costs. Without it,
17 the explanatory value dropped to 7.6 percent. Perhaps most
18 importantly, the case-mix explains one-tenth of one percent
19 of the variation in non-therapy costs, meaning the system is
20 weakest in explaining the services that are most commonly
21 provided. And notably, the case-mix properly identified
22 only 15 percent of high-cost non-therapy episodes.

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

7 Urban developed a revised system that did not use
8 therapy visits as a factor in setting payments and relied
9 solely on patient characteristics. The revised system they
10 developed explained about 15 percent of costs, or about
11 double the explanatory power of the current system when its
12 therapy thresholds are removed. Please note that the
13 prediction estimates for the revised system have been
14 updated and the numbers on the slide here are slightly
15 different from those in the paper we sent you.

16 The improvement was better at the service level.
17 For non-therapy services, the explanatory value of the
18 revised model was 15 percent compared to eight percent for
19 the current case-mix without its therapy thresholds. For
20 therapy services, the revised model had an explanatory value
21 that was more than double the current system without therapy
22 thresholds. The revised system was also more accurate in

1 identifying high-cost non-therapy cases, identifying about
2 28 percent of them, or nearly double the current system.
3 This analysis suggests that an alternate case-mix which
4 drops the therapy thresholds would have better accuracy and
5 better incentives than the current system.

6 This leads to a draft recommendation. It would
7 urge the Secretary to develop a revised case-mix system
8 similar to the one I just described. It reads, "The
9 Secretary should revise the home health case-mix system to
10 rely on patient characteristics to set payment for therapy
11 and non-therapy services and no longer use the number of
12 therapy visits as a payment factor." This would be a budget
13 neutral change. It would increase access to care for
14 therapy patients. Payments will be redistributed to
15 providers that focus on non-therapy services from those that
16 are more focused on therapy services.

17 Now, we have a preliminary model of the impact,
18 and generally, payments would increase for providers that
19 deliver more non-therapy and decrease for those that deliver
20 more therapy. Payments would increase for dual-eligibles,
21 severely ill patients who receive high amounts of nursing
22 and aide services, and at the provider level, it would

1 increase payment for patient-based nonprofit, rural, and
2 small providers.

3 We also plan to reprint the third recommendation
4 from last year's report that sets up a framework for
5 Medicaid safeguards. This recommendation addresses concerns
6 that providers may stint on care when the rebasing is
7 implemented. It reads, "The Congress should direct the
8 Secretary to expeditiously modify the home health payment
9 system to protect beneficiaries from stinting or lower
10 quality of care in response to rebasing. The approaches
11 should include risk corridors and blended payment that mix
12 prospective payment with elements of cost-based
13 reimbursement." And this would be budget neutral and it
14 should maintain beneficiary access to care and provider
15 willingness to serve beneficiaries.

16 Another issue is ensuring appropriate use of the
17 home health benefit. Today, physicians and home health
18 agencies are principally responsible for following
19 Medicare's enrollment and coverage standards, but several
20 studies have raised questions about how effectively they
21 serve this role. Many reports suggest that physician
22 oversight can be weak and the locus of control with agencies

1 which have a financial interest in eligibility -- excuse me,
2 and the locus of control remains with agencies which have a
3 financial interest in eligibility and plan of care
4 decisions.

5 Concerns about overutilization are further
6 exacerbated by the lack of cost sharing in home health.
7 Studies have generally found that beneficiaries consume more
8 health care services when they have limited or no cost
9 sharing and that these additional services do not always
10 contribute to better health. The rapid rise in home health
11 volume suggests that at least some of this growth may be
12 increasing Medicare's costs without improving beneficiaries'
13 health.

14 Adding a copay requirement would permit patient
15 choice to serve as an offset to the incentives in the home
16 health PPS which reward additional volume. However, the
17 copay needs to set appropriate incentives. It should not
18 drive beneficiaries to other high-cost settings and it
19 should minimize negative impact for high-need and low-income
20 patients.

21 One approach is to establish a fixed per episode
22 copay that applies to episodes for community-admitted

1 patients. As pointed out earlier, these are the majority of
2 episodes and one of the fastest growing category of
3 episodes. A copay could be charged at the per visit or per
4 episode level, but given the incentive that providers have
5 to deliver more episodes, a per episode copay seems most
6 appropriate.

7 To protect low-income beneficiaries, dual
8 eligibles could be exempt from the copay. The copay could
9 also exclude episodes with few visits. With this design,
10 about 32 percent of episodes in 2008 would have been subject
11 to the copay.

12 The amount of the copay depends on the minimum
13 value you would want a beneficiary to place on an episode
14 and how strongly you want them to consider alternatives. An
15 amount equal to ten percent, or \$300 per episode, might be
16 an example of an initial value that is appropriate. For a
17 typical episode, this amount would average out to about \$17
18 per visit, roughly in the middle range of the cost sharing a
19 beneficiary would pay for an evaluation and management
20 office visit covered under Part B.

21 To ensure that the incentives of this copay are
22 not diminished by secondary insurance, Medicare could

1 require that beneficiaries pay this out of pocket similar to
2 the true out-of-pocket feature in the Part D benefit.
3 Excluding home health cost sharing would avert an increase
4 in secondary insurance premiums that would result if it was
5 permitted to cover these costs.

6 With these parameters, here is a draft
7 recommendation which would establish a copay as I just
8 described. "The Congress should establish a per episode
9 copay for home health episodes that are not preceded by
10 hospitalization or post-acute care use. To protect access
11 for low-income beneficiaries, dual eligible Medicare and
12 Medicaid beneficiaries should be excluded from the
13 requirement. The copay should be exempt from first-dollar
14 coverage." And this would decrease spending. Some
15 beneficiaries would have to seek outpatient or ambulatory
16 care as a substitute, and providers would experience some
17 decline in demand.

18 And finally, we turn to program integrity. This
19 slide lists the 25 counties with the highest frequency of
20 home health use in 2008. If you compare the share of users
21 and the episode per user for each county to the national
22 average listed below and to the left in yellow, you will see

1 that these counties are well above average in home health
2 utilization. Note that the share of beneficiaries using
3 home health is two to four times the national average, while
4 the average number of episodes per user is also
5 significantly greater than the national average. Five of
6 these counties have more episodes than fee-for-service
7 beneficiaries.

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

16 Medicare has new authorities to fight fraud in the
17 PPACA and home health may be an appropriate place to use
18 these new authorities. Specifically, in areas where the
19 Secretary concludes there is widespread risk of fraud, she
20 can implement local moratoria on the enrollment of new
21 providers and suspend payments for services in areas that
22 appear to have widespread fraud.

1 This brings me to a draft recommendation. "The
2 Secretary, with the Office of the Inspector General, should
3 conduct medical review activities in counties that have
4 aberrant home health utilization. The Secretary should
5 implement the new authorities to suspend payment and the
6 enrollment of new providers if they indicate significant
7 fraud." And this could potentially decrease spending, and
8 appropriately targeted reviews should not significantly
9 affect beneficiary access to care or provider willingness to
10 serve them.

11 This completes my presentation and I look forward
12 to your discussion.

13 MR. HACKBARTH: Okay. Thank you, Evan. Well
14 done.

15 Today is a new day for the timekeeper and I'm
16 under pressure today because people have plane reservations
17 and train reservations, so we're going to adhere closely to
18 the schedule.

19 Before we launch into our round one clarifying
20 comments, I want to raise a couple issues that I'd like
21 people to think about and ask clarifying questions about
22 during round one and make comments on in round two.

1 Evan has laid out a package of recommendations,
2 five in total, plus re-running last year's recommendation
3 with regard to looking at modifying the payment system using
4 risk corridors or blended payment. So there are a lot of
5 moving parts here.

6 One of the issues that I'd like you to react to is
7 the sequencing of these different recommendations. So, for
8 example, obviously one of the recommendations is to rebase
9 the rates, but we're also talking about changing the case-
10 mix system in order to redistribute the dollars. We're also
11 talking about potentially moving away from fully prospective
12 payment to one that is blended payment or at least includes
13 risk corridors. The sequencing of those things could
14 matter, and I want you to think about that and react to that
15 when we get to the round two comments.

16 DR. CHERNEW: Do you mean the sequencing in the
17 chapter --

18 MR. HACKBARTH: No. Operationally -- the policy.
19 The policy. Does the order in which we do these policy
20 changes matter? So food for thought there.

21 DR. DEAN: Evan, as you know, I've been concerned
22 about this area for some time. You said that the case-mix

1 changes would be beneficial, you thought, to smaller
2 providers, if I heard that right. Do you have any idea of
3 the magnitude? Because I think in my area that's the major
4 concern. We've got a whole lot of very small providers,
5 many of which are marginal or non-existent at this point.
6 And there's obviously a huge variation across the country in
7 terms of Medicare expenditures per beneficiary.

8 Without getting into a lot of detail, is it
9 anticipated that this change would even out some of that?

10 MR. CHRISTMAN: I guess I'll start with the small
11 providers comment, and the boost they get, it's real but
12 it's not big. It's about 2 percent. And that's principally
13 -- you know, there's nothing in the model that specifically
14 is geared to an agency size. It's just that they're doing a
15 little bit more of the non-therapy, and the payments for
16 those episode types go up. And so that's why they come out
17 ahead.

18 In terms of the spending, I think it would have
19 some effect nationwide, but I don't know that there would be
20 a huge shift in what you see from the per capitas today.
21 But we haven't really looked at that.

22 DR. DEAN: The other issue, of course, in rural

1 areas is travel time, and that can probably double the cost
2 of the visits. Is any of that involved in this new
3 adjustment?

4 MR. CHRISTMAN: This does not. This looks simply
5 at patient severity. You know, travel time is something
6 that is a very difficult issue for us to look at because,
7 frankly, we hear that concern from providers in all
8 settings.

9 DR. DEAN: Yeah, well, I understand that.

10 DR. MARK MILLER: Can I ask a couple things?
11 There was a rural effect as well, right?

12 MR. CHRISTMAN: Yes, the rural does go up. If I
13 try and do the number off the top of my head, I won't say it
14 right.

15 DR. MARK MILLER: And also hospital-based?

16 MR. CHRISTMAN: Right.

17 DR. MARK MILLER: And the reason I bring that up
18 is because, Tom, you've raised both of those issues before
19 in your comments.

20 Then on the travel point, is there a change in law
21 that addresses that?

22 MR. CHRISTMAN: No. Well, it's one of the issues

1 that CMS is charged with studying --

2 DR. MARK MILLER: That was it.

3 MR. CHRISTMAN: -- as a part of their look at
4 potential refinements.

5 DR. MARK MILLER: All right.

6 MR. CHRISTMAN: But I guess, you know, on this
7 front we've had people from very urban areas come and tell
8 us the same thing, that because of congestion or what-not
9 that their areas are difficult to get around and they have
10 higher travel costs. And so it's something that may deserve
11 some attention, but whether we'll be able to find relative
12 differences I think is an interesting question.

13 DR. NAYLOR: Thank you for this great paper. On
14 the case-mix refinement, proposed refinement, to what extent
15 is comorbidity being captured? It wasn't captured in
16 earlier OASIS, the extent to which having multiple complex
17 conditions affect outcomes. And cognitive impairment, to
18 what extent is that -- you lay out here some of the areas,
19 but I was wanting to make sure that those factors were...

20 MR. CHRISTMAN: We haven't done anything
21 explicitly going down the comorbidities alley too far, and
22 that's because we were sort of starting from scratch and

1 rebuilding a whole system. I think we could think about
2 that. You know, when CMS did its refinements in 2008, they
3 added some comorbidities. And I think the difficulty is
4 that overall we find that diagnosis isn't as limited in how
5 correlated it is with home health use. So you can add some
6 of those comorbidities. How much additional explanatory
7 value you really get is -- go ahead. I'm sorry.

8 DR. NAYLOR: I was just going to say across our
9 work, which has now spanned a long time, the sheer presence
10 of multiple comorbidities, reinforced by Gerry Anderson and
11 others, really impacts the care needs and complexity. And
12 that's been absent in case-mix for home health, and I think
13 if we're moving forward, it would be great -- cognitive
14 impairment adds greatly to the complexity of the care needs
15 in the face of these, and I think it would be great to
16 consider.

17 MR. CHRISTMAN: I'm sorry. I can't recall off the
18 top of my head, but there are some cognitive things in the
19 model.

20 DR. NAYLOR: Okay. The second thing, which goes
21 to the threshold for co-pay and dual eligibles would be
22 exempt, but how did you arrive at that threshold?

1 MR. CHRISTMAN: Of \$300?

2 DR. NAYLOR: Yeah.

3 MR. CHRISTMAN: We started off thinking, you know,
4 normally co-payments in Part B, for example, coinsurance
5 runs 20 percent, and that would result in a co-pay of \$600.
6 And we just felt that that was probably a bit of a big jump
7 to go from zero to \$600, and so, you know, 10 percent, \$300,
8 became I think what we were just offering as, you know, a
9 discussion target. It just comes out arithmetically also.
10 That's kind of in the range of what a beneficiary would pay
11 for some types of outpatient physician visits. And that's
12 offered just as a comparator, not as something that's
13 instructive. You know, it really comes down to the two
14 points that I mentioned, which is sort of what's the minimum
15 value that you'd want a beneficiary to place on these
16 services and how much do you want them to think about
17 alternatives. I think from at least my perspective, I don't
18 have more guidance to offer than that.

19 DR. NAYLOR: Thank you.

20 MR. BUTLER: On page 23, the one that gets your
21 attention, I'd like to understand not just the fraud and
22 abuse piece but the variation question just in general and

1 how significant it is. These numbers suggest about at least
2 twice as much number of episodes per users and two to four
3 times as many -- so maybe six times the national average in
4 utilization, if you'd kind of do the simple math. But these
5 are small number accounting.

6 So at the two ends of the spectrum, do you have
7 any sense, like, you know, 10 percent of the counties use 50
8 percent of the home health, or any other -- a number of
9 counties have almost none? So, you know, what's the
10 variation whether or not it's due to fraud and abuse?

11 MR. CHRISTMAN: Okay. So in terms of the percents
12 in counties like you talked about them, I haven't racked it
13 up that way, so I don't know. The variation that we've seen
14 in home health among counties is greater than any of the
15 individual payment systems we've looked at. So there's more
16 variation in home health than hospice, than physician
17 services, and other things. And as I recall, the variation
18 between sort of the price-adjusted and health status-
19 adjusted variation is about twofold between the CBSA at the
20 75th percentile and the CBSA at the 25th percentile, so in
21 the interquartile range there. And it goes to sort of
22 threefold if you look at the 10th and the 90th.

1 In Hildalgo County, there's McAllen, Texas, and
2 that variation is about, I believe, six or seven times the
3 national average -- again, at the per beneficiary level in
4 health and price adjusted.

5 DR. MARK MILLER: We can also come back with, you
6 know -- what you asked is doable. We can come back with a
7 more specific statement about this many counties account for
8 this much of the spending, that type of thing.

9 MR. BUTLER: My interest is not just, you know,
10 the obvious targets, but what is the variation and
11 ultimately how is it complemented by SNFs or the presence of
12 other services? Just to get a sense of what's going on in
13 the communities.

14 DR. MARK MILLER: We can speak to some of that.
15 There was a presentation, I want to say either in September
16 or October -- I can't remember right at the moment -- and we
17 continued to do some work. When you look at variation
18 across the country, a lot of the variation does seem to be
19 driven by differences in post-acute care. And, two, there
20 is some assumption, but, yeah, doesn't one of these things
21 substitute for the other? Not so much. You're high, you're
22 high.

1 MS. UCCELLO: I'm thinking about the co-pay and
2 the incentives to drive people into other services,
3 especially if supplementary coverage fills in the cost
4 sharing for these other services.

5 MR. HACKBARTH: Could I suggest we come back to
6 that in round two? I think that's a really important issue.

7 MS. UCCELLO: Okay.

8 MR. HACKBARTH: Unless there's just --

9 MS. UCCELLO: My question was just how
10 substitutable are these. Is that two?

11 MR. HACKBARTH: Yeah. You know, I don't think
12 that there's a simple answer to that, and it's going to take
13 some discussion. So let's come back to it.

14 MR. GEORGE MILLER: Yes, I want to address that
15 issue but will do it in round two.

16 Slide 5 and Slide 12, I've got the same question
17 for both of those slides. That is, the increase in admitted
18 patients from the community increased by more than 10
19 percent annually. Do you have that broken down for for-
20 profit and not-for-profit for that increase? And on Slide
21 12, the same question, number of home health agencies
22 continue to grow. Do you have the growth for for-profits

1 and not-for-profits?

2 MR. CHRISTMAN: The growth in agencies has been
3 predominantly for-profits, so I'm going to say 80 to 90
4 percent has been for-profit. But, you know, with that said,
5 I would just remind you that the financial performance
6 differences between the for-profits and the nonprofits is a
7 very small sector.

8 MR. GEORGE MILLER: I saw that. Very well taken.
9 But still the predominance of the growth and the explosion,
10 and in McAllen, Texas, is for-profit. Okay.

11 DR. BERENSON: Could you go back to 23 again where
12 Peter was? I want to just pick up that substitutability
13 question. I'm interested in the interaction between the
14 home health in Medicare and home and community-based
15 services in Medicaid. Well, first, just a simple question.
16 What's the percentage who are duals, do you know?

17 MR. CHRISTMAN: It's between 35 -- episodes,
18 between 35 and 40 percent.

19 DR. BERENSON: 35 and 40. In general, are home
20 and community-based services provided by Medicaid through
21 sort of waivers and home health complementary services? Or
22 is there a substitutability component? I mean, do they work

1 together or do they work as substitutes, I guess is my
2 question.

3 MR. CHRISTMAN: My understanding of this is not
4 very strong, but it's sort of similar to the SNF world. I
5 think whenever they can move folks into the Medicare
6 benefit, they do, you know, if they qualify. But whether
7 they function in a complementary manner the way you're
8 describing, I'm couldn't -- I'm not sure I can --

9 DR. BERENSON: I mean, because it's striking. I
10 mean, there's other hypotheses, but when you're looking at
11 Texas and Mississippi and Louisiana and states like that, I
12 mean, I just raise the question of whether they're not
13 really providing an alternative in Medicaid, and so at least
14 there's some attempt to use Medicare as the source of care.
15 I mean, also personally having visited some parts of Texas
16 and seen that there were six home health agencies in a town
17 of 2,000 people, I don't think that's the whole issue. But
18 I'm wondering whether it is playing a part, and I think we'd
19 want to look into that.

20 MR. CHRISTMAN: There are a number of areas on
21 that chart that are areas that have seen lots and lots of
22 growth in agencies. And so, you know, you have a concern

1 that's part of the story. But there are a few that are as
2 you're laying out. You know, I believe it's either
3 Louisiana or Mississippi, for example, that has certificate
4 of need and just hasn't seen a lot of growth in agencies,
5 but we still see a lot of growth in volume and growth in
6 high use.

7 MR. KUHN: Evan, one issue didn't come up, and I
8 just want to check and see. The issue of the outlier, the
9 kind of charging that we saw a couple years ago that CMS
10 tamped down, has that issue been pretty much dealt with? Or
11 is there going to be needed an additional policy work in
12 that area?

13 MR. CHRISTMAN: They made a number of changes that
14 I think we kind of have to see how they work. The two
15 changes they made were -- just briefly, there were agencies
16 that were manipulating their billing to charge for outlier
17 episodes and get high payments for services that either
18 weren't covered or were much cheaper than what Medicare
19 assumed they cost. So they were able to make money on
20 outliers, and CMS took two actions. One is they shrank the
21 size of the outlier pool; it puts fewer dollars at risk.
22 They went from a 5-percent pool to a 2.5-percent pool. And

1 they implemented an agency cap such that for no individual
2 agency no more than 10 percent of their Medicare payments
3 could be outlier payments. So if they exceed that cap in
4 outlier payments, they have to give it back.

5 So, you know, I think that will have a significant
6 effect. There are agencies that had very high rates of
7 outliers. My understanding, you know, one home health
8 executive told me -- an association executive told me that
9 their phone was ringing off the hook because some agencies
10 felt that their business plans had been exploded, and they
11 were trying to figure out how to function in this new world.

12 So that change went into effect, if I'm counting
13 my years right, in the 2010 payment year. So I think we're
14 kind of waiting to see what happens there, and right now
15 we're kind of just focused on fixing the core case-mix.

16 DR. STUART: My question regards the
17 interpretation of the data on Slide 7. We've seen this
18 before, and the question I have is that the interpretation
19 of the rise in the proportion of the population that meet
20 these criteria and the expression both here and in the
21 chapter is that this represents an increase in quality of
22 care. But my understanding is that these are unadjusted

1 rate. Is that correct?

2 MR. CHRISTMAN: They're adjusted.

3 DR. STUART: They are adjusted.

4 MR. CHRISTMAN: They are adjusted.

5 DR. STUART: For?

6 MR. CHRISTMAN: Differences in, changes in
7 comorbidities, functional characteristics, demographics.

8 DR. STUART: They are adjusted okay. All right.

9 Thank you.

10 MR. HACKBARTH: On that same issue, in previous
11 discussions the question that has come up about these
12 measures is are they truly objective measures. Do you want
13 to address that, Evan?

14 MR. CHRISTMAN: Sure. If I'm following you,
15 there's probably two sets of concerns. One has been that
16 these aren't based on claims data. These is the self-
17 reported information from the industry.

18 And a second concern has been sort of this
19 divergence between the adverse event rates and the
20 functional rates. The functional rates show improvement.
21 The adverse event rates kind of stay steady.

22 You know, a third concern has been that these are

1 sort of broad measures of quality, so, for example, they
2 show improvement in walking even for people who may not have
3 shown up at home health with a walking dysfunction.

4 So we have some work underway that addresses some
5 of these things where we can. We're looking at clinically
6 focused measures that look at improvement in walking for
7 patients that just received a hip and knee replacement, and
8 we are looking at claims-based hospitalization rates so
9 that, you know, we can use that data and see how it compares
10 to the self-reported data.

11 I think that sort of describes the past concerns
12 and sort of what we're doing to come up with alternative
13 measures.

14 DR. BAICKER: Just a brief follow-up on that. I
15 would think the risk adjusters are unlikely to be perfect,
16 and so this is also consistent with the story where as you
17 just start getting more people enrolled, you're marching
18 down the distribution, so it's a selection story even with
19 the adjustment. You're getting healthy people in and they
20 can walk real well.

21 My other question may be in the category of round
22 one and a half, but it does have a factual nub, which is,

1 I'm really interested in the interaction of Recommendations
2 2 and 4, which both seems like great ideas, to foreshadow
3 round two. But what I'm not clear on is how we would expect
4 them to interact if they were deployed together. For
5 example, are the services where you want people -- when
6 people are paying more, you expect some services to get cut
7 back. Are those the services that are being overcompensated
8 now? So how would you expect introducing this co-payment to
9 affect your ability to go back and do the better payment
10 system? That's a question in the long run about the
11 elasticities of different kinds of consumption, but in the
12 short run, the models are all based on the behavior from the
13 previous pricing regime. You introduce a co-payment, all
14 sorts of things shake out differently. How do you build
15 that into the model of what the right risk adjuster should
16 be?

17 MR. CHRISTMAN: Sure. I haven't thought too much
18 about this question, but I guess what I would say is, you
19 know, the case-mix adjustment, the purpose of that is to pay
20 more accurately for services, and it will increase payment
21 for the non-therapy and decrease payment for the therapy.
22 And that has definitely been one driver of volume, people

1 favoring those therapy cases. But whether that would affect
2 the number of patients coming from the community, I don't
3 think it would and here's why. I think that it comes down
4 to the fact that about 10 percent of beneficiaries go to the
5 hospital at all during the year, and so from the agency
6 perspective, the pool of potential patients that they've
7 sort of been expanding it to in the community-admitted is
8 just so large. Whether they're going to offer them therapy
9 or non-therapy services, you know, I think that the factors
10 driving in that direction aren't going to be changed by the
11 change in the case-mix. What they may offer or favor may
12 change, but, you know, we've had this situation where
13 hospital discharges have been flat or declining and agency
14 census has been increasing. And so, in some sense, there's
15 got to be -- I think the hypothesis is that there's at least
16 some supply-induced demand in there, and what they offer may
17 change, but the fact that the community-admitted patients is
18 just such a larger potential market that many agencies will
19 continue to look there.

20 DR. CASTELLANOS: First of all, good presentation.
21 In your discussion, you mentioned that physician oversight
22 was weak. I know in the material that you sent you

1 discussed that wide window of 90 days ahead of time and 30
2 days afterwards, and there was no discussion at all
3 concerning recertification. I know we had briefly talked
4 about this before. Has there been any more discussion as
5 far as maybe tightening that up from the physician or
6 physician-extended side, similar to perhaps what we've tried
7 to accomplish with hospice?

8 MR. CHRISTMAN: Part of the struggle is that
9 there's already, I think, some measures that are somewhat
10 similar to what we've done in hospice in place and home
11 health, not the exact same, and there's a couple of
12 different questions in there. One is the window, and under
13 the PPACA a beneficiary is supposed to have a prior
14 encounter with a physician or a nurse practitioner before a
15 physician can certify for home health. And out of concerns
16 of maintaining access to care, CMS settled on a window that
17 permits that prior encounter to occur up to 90 days before
18 or 30 days after the physician certifies home health.

19 MR. HACKBARTH: Evan, is there a recertification
20 required for each new episode?

21 MR. CHRISTMAN: Yes, there is. There's a
22 recertification. The physician has to basically sign a

1 legally binding attestation that has False Claims Act and
2 all that good stuff attached to it. And so the wrinkle is
3 that the face-to-face encounter requirement right now only
4 applies to initial certifications of home health. So when
5 they're being recertified, the physician still has to fill
6 out a legal attestation and all that good stuff.

7 MR. HACKBARTH: But no face-to-face for the --

8 MR. CHRISTMAN: No face-to-face.

9 DR. CASTELLANOS: Is there any more discussion as
10 to our tightening that up, specifically recertification,
11 face-to-face and cutting down on the window?

12 MR. CHRISTMAN: It's certainly something that we
13 could consider. I don't remember exactly what we thought it
14 has established for a window in hospice. And I think my
15 opinion is that a more timely evaluation would be valuable,
16 and just in the interest of balance -- I mean, they did it
17 out of concern of access to care, so there are folks on the
18 other side --

19 MR. HACKBARTH: As I recall, in a comment letter
20 we suggested a narrower window, recognizing that it would
21 require a legislative change, but a narrower window may be a
22 good thing.

1 The other time we discussed this, though, Ron --
2 and you'll remember -- we had a draft recommendation to
3 increase physician involvement in this. And I can't
4 remember all the specifics of it, but ultimately we dropped
5 it because we couldn't quite figure out how to make it work.
6 I'm not going to be able to remember all the issues, but I
7 remember well Tom saying that he was uncomfortable with the
8 ability of physicians to monitor the use of the benefit,
9 that they don't have the knowledge.

10 So it's definitely an area of interest, and we can
11 go back to it. We need to bring forward that past
12 discussion and see if we can use it as the foundation.

13 DR. CASTELLANOS: Thank you.

14 MS. HANSEN: Evan, you said something actually in
15 response to one of the questions just asked. Did I hear you
16 say that 10 percent of the Medicare beneficiaries have a
17 hospital episode in any given year? Or did I mishear?

18 MR. CHRISTMAN: I hope I said that, yes, and I
19 hope it's right. But that's the number --

20 [Laughter.]

21 MR. CHRISTMAN: I mean, if you know something
22 different, please tell me. But I believe that's the number.

1 I make it a point of having this conversation with the
2 hospital folks, and I believe that's what we landed on last
3 time we had the conversation.

4 MS. HANSEN: I actually would like to follow up on
5 that just so that we get a sense so that if there are about,
6 say, just on the average, for the Medicare beneficiaries who
7 are 65 and older, it's under 40 million, so that would be --
8 potentially 10 percent of that population would go. So if
9 we could just verify that number, that would be good.

10 MR. CHRISTMAN: Sure.

11 MS. HANSEN: And then, secondly, back to Slide 23,
12 this is just more of -- it just ticked my curiosity of the
13 previous work on, say, the more efficient areas of services
14 in communities that are -- use of Medicare services is on
15 the opposite side, so it would be -- and I saw the earlier
16 chart about the fact that some of the quality indicators of
17 rehospitalizations or other things don't change. But is
18 there a little bit more descriptive sense of the more --
19 kind of almost the -- whether it's the 10 percent that was
20 brought up earlier, but just the more efficient Medicare use
21 counties with good outcomes on the part of beneficiaries.

22 MR. CHRISTMAN: I think we could definitely pull

1 up areas that meet some sort of national average and what
2 they look at. I think the difficulty is that, you know,
3 even this data is a county-level average, and it's going to
4 consist of providers who are really doing the right things
5 and providers who are practicing in the wild, to use the
6 term that's been used before. So really saying that, you
7 know, this county looks good and this may represent some
8 sort of optimum of home health I think would be difficult to
9 conclude.

10 DR. MARK MILLER: The only thing I will add to
11 this is you remember the conversation yesterday, we're also
12 trying to get some data from Managed Care Plan to see what
13 their patterns are like. But each of these always have
14 compromises. Whether you're able to link that to quality
15 outcomes is more difficult. I'm just trying to run this
16 fact to ground. It's about 10 million admissions, but it's
17 closer to 20 percent, I think, of beneficiaries. And I
18 think that was...

19 MR. HACKBARTH: Clarifying questions?

20 DR. BORMAN: Evan, could you put up Slide 14?
21 And, Glenn, this is really a clarification for you, and if
22 you want to defer it to the next round, I understand.

1 This is a compound sentence here, so it's really
2 two things. It's begin the two-year home rebasing and
3 eliminate the market basket. In terms of us thinking to the
4 next part of your question for sequencing, could you share
5 the strength of the linkage? The "and" there, is this
6 something that "if" and "and" together needs to stay
7 together or is this something that we need to consider
8 separately?

9 MR. HACKBARTH: I think the reason -- and, Evan,
10 jump in if I'm off the mark here. But I think the reason
11 for structuring it this way is that PPACA actually says go
12 forward with rebasing, but then also give updates, which has
13 the effect of undoing some of the rebasing. So, you know,
14 if your goal is to bring the rates closer into line with the
15 underlying costs, to go down and then up doesn't seem to
16 make a lot of sense. And so this just makes it clear that
17 we think that there ought to be rebasing and don't turn
18 around and offset part of that through a market basket
19 increase.

20 DR. BORMAN: Thank you.

21 MR. HACKBARTH: Round 2 now. We've got 45 minutes
22 left in this session and, unfortunately, we've also got a

1 lot of different recommendations, so we're going to have to
2 be really disciplined in how we go through this. Let me
3 just also raise one other issue that I'd like people to
4 react to. I raise the question of the sequencing of the
5 recommendations that would influence the rates and the
6 distribution of the dollars.

7 Another issue that I'd like you to react to
8 relates to the recommendation on the co-pay. We have
9 planned for the spring another discussion on restructuring
10 of the Medicare benefit package, and the reason I wanted to
11 offer this here, the home health co-pay is, this is one of
12 the few services where there's zero co-pay today.

13 So one train of thought would be, well, a major
14 overhaul of all of the structure is down the road and may
15 take a long time. A more focused recommendation in one of
16 the areas where we have zero may move more quickly. But
17 again, that's an issue I'd like you to react to. Mitra?

18 MS. BEHROOZI: So on the sequencing question,
19 which I hadn't thought about it at all until you raised it
20 so this is off the top of my head, I mean, what I have
21 thought about since the prior presentation that Evan did
22 about this is that one of the big concerns is not the level

1 of -- is in addition to the level of the margins is the wide
2 variability.

3 So I love the redistributive effect of the case-
4 mix index adjuster, and I think that that's the priority
5 just because that is so much more dramatically worse than in
6 other payment systems, and because we don't want to do harm
7 where there are providers who are trying to do the right
8 thing and provide the non-therapy services. So that would
9 not only protect them, but reward them in a way that they
10 haven't been rewarded and take some of the money away that's
11 not being spent appropriately at the high end.

12 I think consistent with that, then risk -- the
13 whole risk corridor recommendation moves in the same
14 direction of sort of bringing the ends closer to the middle.
15 And then that middle being too high, you know, is what, I
16 guess, would be addressed by rebasing. So while I
17 understand that in current law, the way it's set out, it
18 would take a long time to get there. I don't know that it's
19 so important to necessarily move that up so fast and hard,
20 and that's not really going to solve, I think, the worst
21 problems because, you know, payments have been cut before
22 and volume continues to grow and payments continue to grow.

1 I mean, rates have been cut before.

2 So I think that's, to me, the third in the line of
3 three. Certainly, the final recommendation on doing more to
4 combat fraud I totally support and would go farther
5 probably.

6 On co-payments, I certainly like -- I think that
7 what we need to do, and as you said, Glenn, this is an
8 opportunity to do it in a targeted way, but we need to be
9 consistent with what we want to do on the broader scene,
10 which is to encourage the use of high value services and
11 discourage the use of low value services.

12 So I appreciate that you wouldn't be proposing
13 using -- applying a co-payment to post-acute services after
14 a hospital or a post-acute stay. But then when it comes to
15 the co-payment on the second or from the community episodes,
16 I have some issues with imposing the co-pay as proposed
17 here.

18 First, I think that having it be a flat co-payment
19 doesn't relate it to the value of the services to the
20 beneficiary. I mean, we're starting with the payment system
21 structure to address provider incentives. Right? So we're
22 talking about a 60-day bundle and we're talking about

1 adjusting the case-mix index within that bundle. But to the
2 beneficiary, the 60 days is not relevant to how many
3 services or what type of services they might be receiving
4 within that bundle.

5 So for everybody to pay \$300, or whatever that is,
6 for that same period of time within which they might get 30
7 aide visits or 50 nurse visits is not very targeted in terms
8 of the value to them, unless I'm misunderstanding it. I do
9 note, though, that you said that we could also exempt
10 episodes with very low numbers of visits, and I think that's
11 a good approach.

12 But I think it would be helpful to, I don't know,
13 allow the Secretary or somebody to develop a more targeted
14 or more nuanced kind of approach that addresses it from the
15 beneficiary value standpoint. I think there's also a
16 potential that it doesn't relate to value to the program
17 because if you treat all community admissions the same way,
18 then you might be missing some opportunities to incent the
19 utilization of home care that would avoid a hospitalization
20 or something like that. I know you looked at the post-
21 outpatient surgery category, but again, it might be useful
22 to be more nuanced in the approach.

1 I also think -- and I said this the last time --
2 that a number like \$300 is too high. It's too high for low-
3 income people who are not dual eligibles, and I say this all
4 the time, I know. Sorry. I'm a broken record. Dual
5 eligible is not coextensive with low income. It's really
6 not.

7 Again, if it's the same number for all people who
8 are not dual eligibles, then you're going to have a lot of
9 people at the lower end of the income scale making a
10 decision based on the \$300 that has nothing to do with,
11 really, the value of the services to them. It will just be
12 about the \$300. Again, I think there's evidence that shows
13 us a lot smaller number can be used to drive behavior while
14 mitigating the potential effect of being too high a barrier
15 that will make people avoid needed care.

16 I think, again, we need to look at it from the
17 beneficiary perspective rather than the program perspective,
18 starting with the 20 percent because that's what the program
19 does in other areas. And here's the cost to the program of
20 the benefit just is not looking at it from the beneficiary
21 perspective. If you want to look at driving behavior, I
22 don't think you need to start with, well, 20 percent of the

1 cost of the benefit to the program. You look at what would
2 drive beneficiary behavior in a constructive way, again.

3 But on the point of exempting duals, this is more
4 of a question and relates to what Bob raised about the state
5 interplay. If you exempt duals, wouldn't that mean that
6 you're exempting the state from covering the co-payment and
7 then encourage a little bit more about what Bob brought up
8 about possible shifting of what might otherwise be a state
9 program?

10 And then the substitutability, that kind of also
11 relates to what Cori was raising about would this not only
12 possibly drive people to more expensive post-acute care, but
13 even to hospice, I guess, right, where we see evidence that
14 that's sort of growing into a long-term home care benefit.
15 So I think taking those considerations into account is
16 important.

17 DR. DEAN: Where to start? Just in response to
18 the question about recertification, I guess it is true that
19 we get forms stuck in front of us to sign about which we
20 know very little as to what's actually happening. That
21 isn't necessarily an argument against the concept.

22 I guess, Evan, I'm still not really clear as to

1 what the criteria for recertification is. Does it require
2 that progress be demonstrated? I mean, for instance, when
3 we're using, for instance, physical therapy and their swing
4 bed program, that is the main criteria, that they have to
5 demonstrate progress, and if they do, they can continue. If
6 they hit a plateau, then not. What are the criteria for
7 continuation?

8 MR. CHRISTMAN: As I understand it, really it's
9 the two keys are the same as in initial certification,
10 broadly. Is the patient still home-bound? And they still
11 have a need for skilled care so they still need the physical
12 therapy. Do they still need the nursing service.

13 DR. DEAN: Is need defined?

14 MR. CHRISTMAN: You're wading into waters I just
15 don't know as well.

16 DR. DEAN: And that may be an issue in and of
17 itself, if the criteria for continuing are very imprecise,
18 it certainly --

19 MR. HACKBARTH: So right now, we don't have a
20 recertification draft recommendation on the table for
21 consideration, and there are issues that we would need to
22 think through. Ron has asked that we consider that in the

1 future and we will, but right now, that is not one of the
2 draft recommendations.

3 DR. DEAN: I understand, and I guess I would just
4 say, I would agree with Ron. I think it deserves some
5 exploration.

6 MR. HACKBARTH: What about the existing draft
7 recommendations? What are your thoughts?

8 DR. DEAN: Well, I certainly agree with the
9 direction of them. As far as prioritizing or sequencing,
10 I'm not quite sure. Certainly the fraud issue probably
11 ought to be number one, I would think, and then if the case-
12 mix adjustments and rebasing is -- if there's an expectation
13 that that will result in a more reasonable distribution of
14 the resources, I'm certainly supportive. I guess I'm not
15 sure I understand them well enough to really comment on
16 that.

17 Looking at the data, the wide variation in
18 resources expended per beneficiary is disturbing. The data,
19 I think, that we saw that you folks sent me a while back
20 there's a tenfold difference between expenditures per
21 beneficiary across states, from the lowest users to the
22 highest users. There just isn't anywhere near that much

1 variation in terms of clinical justification or clinical
2 need.

3 So we clearly have a problem. Obviously, it's a
4 complex one to know how to get a handle on it, but obviously
5 I think these are a start.

6 So I guess, you know, how or what the strategy of
7 the sequence should be, I think those are right moves. I
8 guess I still am concerned about the low volume providers
9 that I'm not sure are going to do well in any of these
10 things.

11 The example in the written material of the fact
12 that there's an area where Medicare payments were judged to
13 be adequate, but there wasn't enough Medicare patients to
14 support an agency, and so the agency went out of business,
15 and how we respond to that I'm not quite sure except the
16 bottom line is you have beneficiaries that don't have a
17 service.

18 So I think it still is a worry even though it
19 isn't -- Medicare may be approaching it in a reasonable way,
20 and yet, still -- and that's certainly the case in the areas
21 where I'm at. You have, admittedly, not large numbers, but
22 you certainly have beneficiaries that just don't have access

1 to this service. So obviously I'm concerned. I don't know
2 exactly what the response is.

3 MR. HACKBARTH: In a way, this relates to the
4 rural report.

5 DR. DEAN: Yeah -- [off microphone.]

6 MR. HACKBARTH: Right. The question you and I
7 have discussed via email is when there are situations like
8 this, take the example of home health, Medicare is paying
9 well. There just aren't enough Medicare patients to make
10 the home health agency viable. Is the best way to solve
11 that problem through still higher Medicare rates, or should
12 the Federal Government provide support through some other
13 channel to assure adequate access to essential health care
14 services? So that's a question, I think, is better
15 discussed not in the home health update, but in the broader,
16 what should our policy be towards rural issues.

17 DR. DEAN: And I accept that. I think it is -- I
18 mean, it's an outlier issue and how we respond to it. And
19 like I've said, it's not huge numbers of people. I
20 acknowledge that. And yet, at the same time, there are
21 folks that could benefit. I mean, in our setting, there are
22 other services that fill part of these gaps. That didn't

1 answer any of your questions probably.

2 MR. HACKBARTH: Sort of like I've got the drift.

3 Mary?

4 DR. NAYLOR: So my recommendations in terms of
5 sequencing would be that we would proceed immediately with
6 efforts around the case-mix. I think that there are really
7 important questions about whether or not the right set of
8 people are getting to home care from hospital to post-acute.
9 We still have no change in the needle on readmission rates
10 in 30 days from hospitals, et cetera, and that they're
11 getting to the right and most efficient services.

12 There are some issues around that. So I think
13 that this case-mix work is going to help, really help in
14 helping us to get that path much clearer, right people to
15 the most effective and efficient sets of services which --
16 so I really think that's important.

17 I think this movement around the quality measures,
18 which is not an explicit part of the recommendation, but
19 part of the report, is also equally important, that we get
20 the right set of measures to help us to understand that
21 we've done that.

22 I was also immediately moved on number five, on

1 their review of the Office of Inspector General. Putting
2 back lower and not immediately the recommendations related
3 to rebasing, and then obviously protecting beneficiaries
4 from possible stinting from rebasing, it seems to me, would
5 -- they go together, but I would not put them immediately.

6 I would recommend that we recommend testing the
7 impact of co-pay. I do agree with earlier comments that low
8 income and dual eligibles are not the same, so we would
9 really want to make sure that we were not in any way hurting
10 low-income beneficiaries who absolutely need access to these
11 services and who will absolutely look at that \$300 as just a
12 barrier that they can't overcome.

13 And finally, since it was raised on the
14 certification, I would say this is also an opportunity for
15 us to look at consistencies across the policies in hospice,
16 advance practice nurses, certify, recertify. Here, I would
17 think that we would also want to look at the capacity of
18 advance practice nurses to participate as active players in
19 that process.

20 MR. HACKBARTH: So let me just clarify on thing,
21 Peter, before you go. So, Evan, briefly describe the timing
22 of rebasing as it exists in current law and PPACA.

1 MR. CHRISTMAN: Sure. It would start in 2014 and
2 starting in that year, the Secretary could begin to dial
3 down payments by 3.5 percent in that year and each of the
4 three following years. And then in each year, that 3.5
5 percent would be offset by the market basket update that
6 year, which will be around 1 or 2 percent.

7 MR. HACKBARTH: And so the length of the rebasing
8 process is stretched out by the fact that they're going down
9 and then increasing by the market basket. So to get to the
10 ultimate goal takes more years. Is that right? So you
11 start in 2014 and you have a rather protracted process to
12 get to the destination.

13 So one of the things that I feel pretty strongly
14 about is that we need to rebase and we need to do it and at
15 a pace significantly faster than that. I offered let's do
16 it starting in 2012. We don't need to resolve it today, but
17 even if we were to change the sequencing and say, oh, we've
18 got to do the case-mix thing before we rebase, I would like
19 to still be clear that oh, we're not talking about start in
20 2014 and do it over the next ten years or something.

21 DR. NAYLOR: I totally agree with that.

22 MR. HACKBARTH: Okay.

1 DR. MARK MILLER: Can I get just one other
2 clarification? It starts in '14 or it can start in '14?

3 MR. CHRISTMAN: I believe it's required to start
4 in '14.

5 DR. MARK MILLER: Okay.

6 MR. BUTLER: So just to clarify, I guess, if we
7 had the right system case-mix today, coupled with a good co-
8 pay and you could extract all of the targeted dollars
9 through that means as opposed to rebasing, that would be my
10 preference. So in other words, let's pretend we have the
11 case-mix system done today and we were ready to go with co-
12 pays, I would try to get to the spending target through
13 those two means and not rebasing at all, if there was a way
14 to do it. In other words, redistribute the dollars at a
15 lower amount using the case-mix, and also have a co-pay. We
16 just practically can't do that.

17 DR. MARK MILLER: Can I just ask, and just for
18 clarification, the case-mix, as discussed, is a budget
19 neutral transaction. So what I'm ask --

20 MR. BUTLER: See, I would marry it with the budget
21 goal.

22 DR. MARK MILLER: So I'm going to restate. This

1 is exactly what I'm trying to draw out. You're almost
2 saying something -- I'm asking. You're saying the case-mix
3 would have the effect of leveling out payments. We were
4 seeing that as a budget neutral transaction. Are you
5 suggesting you would say no, you take the payments out of
6 this side? Is that conceptually what you're saying?

7 MR. BUTLER: I think so, yes.

8 MR. HACKBARTH: So a non-budget neutral case-mix?

9 MR. BUTLER: Case-mix. In other words, I'm trying
10 to get the rebasing done in combination. Throw it into the
11 case-mix equation so it's not a budget neutral. I don't
12 think we could do that given that we don't have the case-mix
13 done in a timely fashion. But you said if it had been.

14 MR. HACKBARTH: Yeah.

15 MR. BUTLER: So I don't have an answer to how to
16 do that. But in the end -- my point is, and everybody
17 else's is, you're trying to affect individual behaviors in
18 how the services are delivered at the local level, and
19 rebasing is a blunt instrument that just takes money out of
20 the system and it doesn't do anything about underlying
21 delivery of services and behaviors of the individuals using
22 them, I don't think.

1 MR. HACKBARTH: At the patient level or the --

2 MR. BUTLER: Yeah, or even in the -- let me --

3 MR. HACKBARTH: Well, rebasing. I'm sorry. Go
4 ahead, Peter.

5 MR. BUTLER: It takes profits out of the system.

6 MR. HACKBARTH: Yes.

7 MR. BUTLER: I understand that. It doesn't
8 necessarily change incentives for the home health to do
9 things anything differently.

10 MR. HACKBARTH: Well --

11 MR. BUTLER: Except cheaper.

12 MR. HACKBARTH: For hospitals. We talk about
13 pressure on the rates being an important force in improving
14 efficiency. And so, I think the level of the rates matters
15 a lot. If you have a base rate that is well above the cost
16 of delivering the service, I think that's a problem.

17 MR. BUTLER: It doesn't do anything about the
18 therapy services though, the way the system is skewed.

19 MR. HACKBARTH: And I agree and that's why I
20 haven't said, oh, rebasing is the only thing we need to do
21 in home health. Unfortunately, we've got a lot of things
22 that we need to do in home health. That's why we've got so

1 many recommendations. So rebasing isn't a panacea, but I
2 don't see if we did everything else but rebasing, that would
3 solve the problem either. I think we need to do it all.

4 MR. BUTLER: Right. It's tricky. The other thing
5 I would say, Mitra brings up an interesting point on the --
6 I think you're almost suggesting means testing at a co-pay
7 level, which is, I think you're almost suggesting, at least
8 you said \$300 is too much. You didn't go as far as saying
9 maybe it's \$100 for this group and \$400 for this group. But
10 it's an interesting question because we have limited means
11 testing at the premium level now at Part B and it does have
12 implications.

13 How would you begin to think about it? Because
14 you might have some kind of means testing, but in a
15 consistent way across the various services, I don't know,
16 but it's something that we should think about when we think
17 about the \$300.

18 MR. HACKBARTH: Yeah. And again, it goes back to
19 the question of whether to think about the home health co-
20 pay in isolation or as part of a broader redesign of the
21 benefit structure. Mike?

22 DR. CHERNEW: So first let me say I find these an

1 absolutely wonderful set of recommendations and I'm rarely
2 that positive as an economist. So first --

3 MR. HACKBARTH: I'm worried. What comes next?

4 DR. CHERNEW: My goal is three minutes so I'm
5 going to talk quickly. First let me point out that if
6 someone is unfortunate to get stricken with cancer, they
7 have a huge set of co-pay requirements. Is someone,
8 unfortunately, has a heart attack, they'll pay hospital co-
9 pay requirements that dwarf any of the things we're talking
10 about here. That said -- so I'm very supportive of the co-
11 pay. I think \$300 is too high for the reason Mitra said. I
12 think you can much of the bang for a substantially lower
13 number, so we'll have to discuss what the number is.

14 But the idea of not having a co-pay, I think, is
15 incredibly inequitable to people that have -- we basically
16 tax poor and rich people who have things that there's no
17 behavioral thing that they can do to get around it. There's
18 no evidence of fraud. There's none of these other
19 beneficial things that this co-pay might do. So I think
20 relatively speaking, the co-pay one is very important.

21 I want to say that it's very important that we do
22 this in a way that doesn't make the admin part really

1 burdensome. So while I think it will be nice if we could
2 have physicians certify people, I hardly think that's
3 costless.

4 So I think some of these other tools, before I
5 went through all these administrative things where I have
6 people having to do this and you have to fill out that
7 paperwork and you're going to have to do this thing with
8 this oversight, I think a lot can be done if you try and get
9 some of the payment and incentives right before you layer on
10 a bunch of administrative things.

11 So that's why I really like the attitude behind
12 many of these proposals, which I think go in the spirit of
13 setting payment incentives right. So I think, for example,
14 the case-mix stuff is extremely important. I'm worried
15 about saying to order that first. I think we need to start
16 on it immediately, but I think we can do things.

17 I would have put first, honestly, the fraud. The
18 fraud stuff undermines support for the program. We will not
19 have this program, we will not have rates that make this
20 program viable if we can't control the spending. Everybody
21 wants to control the spending that's fraudulent, let alone
22 not valuable. Let's ignore the not valuable but not

1 fraudulent stuff because otherwise we're not going to be
2 able to preserve the care that is so important for everybody
3 else to get -- that we all agree on. So I think the fraud
4 has to be done immediately in practice as we work on the
5 case-mix stuff.

6 I think the co-pay stuff should go in as soon as
7 we could do it. I would like to make it part of a broader
8 benefit design thing, but I wouldn't want to hold it up to
9 wait for that. I think the rebasing part is important. The
10 one that I would put last, if I was doing all of these ones,
11 is the blended payment recommendation three, and the reason
12 is, I find it sort of goes everywhere with we're going to do
13 some of this, some of that, with these corridors.

14 So unless I learn more and think more about just
15 the implementation speed with which one can do all of those
16 various things, it strikes me as taking Peter's basic view
17 of we do the case-mix stuff and the co-pay stuff, the
18 rebasing is important. I'm very supportive of the
19 recommendation three on the blended payment amounts and
20 corridors and all of that stuff, but I think we might not
21 need it quite as badly as we got some of the other things
22 done. So I might make that one last, if you asked us to

1 prioritize these, which you did.

2 MR. HACKBARTH: It occurs to me now that maybe the
3 new Commissioners, this recommendation about corridors and
4 blended payment may just be way too abstract, and so let me
5 just really briefly recount the history here.

6 This was an issue that over time Bill Scanlon
7 persuaded me was an important problem. And Bill's argument,
8 which I ultimately found compelling, was that to have a
9 prospective payment system you need a well-defined product,
10 and home health is not a well-defined product. It's quite
11 amorphous and malleable depending on how people want to use
12 it.

13 And so, he thought it was ill-suited to a fully
14 prospective payment. That's one of the reasons that you
15 have (a) very high profit levels, and (b) a really wide
16 range of profitability. And so, Bill said, in recognition
17 of how ill-defined this product is, we should move away from
18 fully prospective payment and use a system like blended
19 payment or risk corridors that would, as Mitra pointed out,
20 narrow the distribution. Take some money away from the very
21 high profit agencies and maybe put a floor under some of the
22 low profit and just really tighten up the distribution of

1 financial performance.

2 The language here is carried over from our last
3 discussion of this. We stopped short of saying, we know
4 exactly which to use, risk corridors versus blended payment.
5 We thought it required more study. So that's where this
6 comes from. Cori?

7 MS. UCCELLO: I am generally supportive of all of
8 these recommendations. I agree with a lot of what Mike
9 said. In terms of the sequencing, you know, I'm not sure I
10 really have much to add on that. I think the case-mix -- I
11 think rebasing before the case-mix could just exacerbate the
12 problems of some of the inequities there.

13 In terms of the co-pay, in general I am very
14 supportive of co-pay mechanisms. Clarification, I mean,
15 we've been talking about this \$300 number, but we don't have
16 a number in the recommendation. Are we explicitly kind of
17 leaving that or implicitly leaving that to the Secretary?
18 Or do we really want to come up with a number? Just with
19 respect to that, too, I agree that \$300 gut-wise just seems
20 high, especially if I think about this, you know, no-first-
21 hour coverage and the substitutability and other kinds of
22 things. But if that were \$100 instead, I think you would

1 still get -- I mean, it still serves as a signal to people,
2 and then I would be less concerned about some of these other
3 issues.

4 MR. CHRISTMAN: Could I just say -- and this is
5 just a point of clarification. You know, the co-pay amount,
6 it is just sort of a stalking horse we put out there. But
7 the point I guess I would just make is that as you go below
8 \$300, on a per visit amount home health is going to be
9 cheaper than going to the doctor when it's more expensive
10 for Medicare. So --

11 MS. UCCELLO: So you get substitution the other
12 way.

13 MR. CHRISTMAN: Yeah, and again, there's a lot of
14 factors you're going to weigh when you do the co-pay, and
15 the optics of \$300 is a lot. And so I don't want to
16 dissuade anybody, but I just want to --

17 MS. UCCELLO: But it's also \$300 -- that's also,
18 you know, 17 if you're at the average, and even -- you know,
19 what if you're at five, which is higher than visits, which
20 is -- you know, where do you set that? So I just -- you
21 know, signal-wise, just trying to get that right place.

22 MR. GEORGE MILLER: Yes, I agree with Mike that we

1 should address the fraud issue first, and in general, I'm
2 comfortable with most of these recommendations. The one I
3 have a little bit of trouble with that everybody's
4 discussing is the co-pay. Had you come and said we need to
5 redefine benefits because this particular product line, home
6 care, needs to have a co-pay, I would be fine with that
7 separately.

8 My problem is that we're trying this in an
9 industry where apparently there's a lot of fraud, and one
10 solution -- and these are my words -- seems to be there's
11 fraud here and so how to solve the problem is we should have
12 a co-pay and have people help pay for services and benefits
13 they may not necessarily need. You take that aside, then I
14 don't have a problem with the co-pay, but I agree that it
15 should be probably, like Peter, means-tested to have that
16 co-pay.

17 One thing that could be -- since we're talking
18 about redistributing some of these services and
19 reallocating, maybe instead of talking about a co-pay but
20 maybe a beneficiary sharing I helping to reduce some of the
21 costs in some way. I don't know the answer to that. I
22 don't have a solution. And maybe co-pay is a better

1 solution, but if we try to achieve some savings in this
2 market, maybe having the beneficiary share in some of that
3 savings may be a way to think about it.

4 So, in general, I support the recommendations. I
5 think fraud should go first. I could be persuaded about the
6 co-pay, but it depends on what order and the sequencing.

7 DR. BERENSON: I support a co-pay, although this
8 discussion suggests the need for quickly having that spring
9 conversation because while I think \$300 may be too much --
10 and yesterday it was noted again that the SNF after 20 days
11 is \$141 a day, that can add up to lots of barriers to
12 access. The hospital first stay is over a thousand hours,
13 something like that. So it's hard to have this discussion
14 without having the bigger discussion, but I think it's
15 reasonable to do it and to make the recommendation.

16 As I said yesterday, I think I would use the same
17 argument to have a co-pay in hospice as well. I didn't
18 quite follow Mitra's logic as to why you want to not pay on
19 the per episode basis. You know, some patients go into the
20 hospital for two days or three days and have the same first-
21 day co-pay as somebody in the ICU for three months. Maybe
22 that's not the right way. I'm not sure what marginal

1 decision you want the beneficiary to make based on the
2 latter days, but this is not the time to have that
3 conversation, I think. I think we do need to have a good,
4 robust discussion of this in the spring.

5 On sequencing, I'm not sure I see much need for
6 sequencing. The rebasing, as I understand it, it's in law
7 to begin in 2014, and we're suggesting we move it up. So I
8 think that if we're going to do it, it has to go right away,
9 and Congress will either do it or they won't do it. The co-
10 pay is another thing that Congress has to do, and we want to
11 recommend that.

12 If it's the Secretary who has to do the case-mix
13 work and then sort of the more complicated risk corridors,
14 that kind of thing, that latter is going to take awhile. I
15 mean, that's not going to be anything they're going to do
16 right away. If, in fact, the rebasing, Congress does pass
17 that, moves it up, then I think CMS takes that into account
18 with any transition they do in the case-mix. I mean, I just
19 think that we want to push all of this stuff out quickly,
20 and I don't see any sort of logic that you have to wait for
21 one to be done before you can propose the next one. I just
22 think you just -- I don't think we have that kind of control

1 over the different actors and to how they're going to do all
2 of this stuff.

3 So I would be for making these recommendations
4 without a recommendation on sequencing.

5 MR. KUHN: As I think about the sequencing issue,
6 I really want to -- where I'm thinking about it is a little
7 bit where Mary was. What are the items that are going to
8 accelerate and help us get to -- or create a better platform
9 for hospitals and other health care organizations to deal
10 with readmissions, ultimately get to ACOs, et cetera? What
11 if any of these things could help accelerate towards that
12 integration and create that platform? Particularly when you
13 look at the data on page 7 and you look at the final two
14 things, any hospital admission and any urgent care, we're
15 not making any progress in those areas. And any of these
16 recommendations that can help accelerate us in that
17 direction to move forward would be where I would think on
18 the sequencing. And of all the things that we have before
19 us, I think the case-mix probably does the best or probably
20 would be the one that would help us create that better
21 platform and improve the system that would make it easier to
22 implement the readmission issues, those kinds of things that

1 are out there.

2 So I would think we would go there as we go
3 forward, although I think Bob makes some pretty persuasive
4 arguments that it's just kind of all in.

5 On the issue of the co-pays, to help me kind of
6 think this one through -- and I do think \$300 is very high.
7 But what would help me to think this one through a little
8 bit is to look at little bit more at the underlying bad debt
9 policies that we see with other providers out there. We've
10 talked about hospitals, but hospitals, there is a bad debt
11 provision in current Medicare law which I think covers up to
12 70 percent of the bad debt after due diligence in trying to
13 collect. But there's no bad debt opportunities for Medicare
14 to recover for other provider types out there, and it would
15 be interesting to see for physician offices these other kind
16 of settings out there, what's the absorption rate of the
17 providers on the bad debt side of this and to see what's out
18 there.

19 One could argue that with the kind of margins
20 we're seeing here with home health, there's plenty of room
21 to absorb some bad debt here, and it shouldn't create an
22 access issue. But I'd like to kind of understand a little

1 bit what goes on in the other provider areas. Are we seeing
2 bad debt go up because of the economy going down? Would
3 that create a barrier? So that would help me kind of think
4 that one through a little bit more.

5 DR. KANE: Well, I think since a 17-percent margin
6 kind of gives you -- it attracts a lot of people that you
7 don't necessarily want to have in the business since it has
8 no capital requirements. I mean, they might need a little
9 bit of IT, a little bit of a management control system, a
10 little bit of worker training, and then it's like gravy. So
11 I think my first priority would be to get rid of the 17-
12 percent profit margin because it's just attracting in a lot
13 of people who are not necessarily there for the right
14 reasons. And I'm not talking for-profit or not-for-profit.
15 I just think that's just way too much. So, therefore, the
16 rebasing -- by the way, as I recall, there was something
17 like double the number of visits in the old system, in the
18 old episodes, upon which the current rates are based, as
19 there are now -- change in skill mix but also like double
20 the number of visits.

21 So let's just get down to the right amount, and I
22 think that will solve some of the problems and who's in this

1 business and who's doing the stuff they shouldn't be doing.

2 MR. HACKBARTH: I really agree with that point.

3 You know, it's an invitation to fraud to have huge profits.

4 But on the declining visits, I think it was from the low 30s
5 to low 20s.

6 DR. MARK MILLER: Correct.

7 MR. CHRISTMAN: Right. It was 32 to 22.

8 DR. KANE: 32 to 22, and then a change in mix that
9 goes with higher skill.

10 MR. CHRISTMAN: Right.

11 DR. KANE: But, still, that's a big chunk of --
12 you know, what are we doing paying for that? I do think the
13 case-mix is a no-brainer. Why not? You know, it obviously
14 does the right things and rewards the right kind of
15 behavior. And I do think that the fraud deterrent -- I
16 mean, is there any way we can, you know, pay home health
17 people -- Medicare beneficiaries who get approached with
18 inappropriate marketing, I mean, I just think there's all
19 kinds of reasons we should try to get rid of the bad actors
20 in this business.

21 And on modifying the system with corridors and all
22 that, I know I must have voted for that recommendation, but

1 I guess I'd rather see that energy spent towards, you know,
2 what Herb was just talking about. What kind of outcome
3 measures should we be focusing on and trying to encourage
4 and build into the payment system rather than, you know,
5 making sure that everybody -- from a financial way that they
6 all get -- I'd rather say let's do it more from the outcome
7 measure, that people don't get stunted because they had
8 better outcomes because they're using the hospital, they're
9 not being admitted to the hospital or urgent care.

10 On the co-pays, I'm very conflicts on this. I
11 think picking one group that has to pay and another group
12 that doesn't gets a little dicey because we've been trying
13 to push substitute of inpatient care with outpatient care,
14 and, you know, there's ambulatory surgery. So, you know,
15 are they going to have to pay the co-pay, but if you had
16 your surgery inpatient, you know, you don't.

17 There's also all the chronic disease management
18 programs we're trying to see get going where home care is a
19 central part of some of them, home monitoring systems,
20 intervention. So I'm kind of not sure we know where to put
21 the co-pay to encourage value as opposed to discouraging
22 inappropriate utilization. So I kind of think that's

1 something we should recommend that we should maybe study,
2 but I'm not sure we're ready to make that kind of a broad-
3 based recommendation. I'm all for co-pays, but I think we
4 should try to think about how to structure it to encourage
5 more appropriate utilization, but when we don't know what
6 that is, it's a little awkward to just say, well, because
7 you came in from the hospital but you didn't. You know, I'm
8 not comfortable with that. I think that's the one I'm the
9 most uncomfortable with.

10 DR. STUART: I strongly support Recommendations 1,
11 2, and 5, and I think that order is fine. I don't support
12 number 3. I understand Bill Scanlon's arguments on this,
13 but the arguments are based on frustration, I think, rather
14 than based upon any empirical evidence that this thing would
15 actually work. And I'm really impressed with the analysis
16 that Urban did regarding the case-mix, and so I would say,
17 you know, before we say anything about bring cost
18 reimbursement back, "Ahhh," I just don't want to do that. I
19 would put my nickels on the case-mix. So I would get rid of
20 number 3.

21 I'm also not at all sanguine about number 4 on co-
22 pay, and part of that -- there are two basic reasons why.

1 I'm not opposed to cost sharing, but if you think about it,
2 co-pays are generally applied to relatively low-cost -- not
3 always but relatively low-cost services that are provided in
4 some kind of a sequence. And so the question is, well, do I
5 want to continue to use this brand-name drug or am I going
6 to use a generic drug, or do I continue to go to the
7 physician or maybe I visit some other type of practitioner.
8 So it has to do with what the margin is, and the margin
9 here, as I understand it, is a \$6,000, approximately, cost
10 of an episode. So the question that would be relevant to
11 the beneficiaries is, Well, do I have the whole episode or
12 do I have none of it? And I'm just uncomfortable about
13 that, and I think that Nancy has raised that.

14 I don't know of any evidence base that would be
15 relevant to understanding what a co-pay, whatever the level
16 is, would actually have in terms of numbers of episodes.
17 And, in fact, is that something that we really want
18 beneficiaries to do? Or does it get back -- and I don't
19 want to raise this as a large issue, but it comes back in.
20 Is it really the definition of the episode that we're
21 concerned about? Maybe the episodes shouldn't be as long as
22 they are. Maybe they should be shorter. Maybe there should

1 be fewer resources within the episode. The co-pay wouldn't
2 affect that at all. And so I'm not opposed to cost sharing,
3 but I don't think co-pay is necessarily the right way to go
4 about this.

5 The second piece, I think I heard you say, Evan,
6 that -- maybe it was just in those counties, but that home
7 health is heavily used by duals. Was it 35 --

8 MR. CHRISTMAN: That was a nationwide number.
9 That was not just in those counties.

10 DR. STUART: Okay. Well, whatever the number is,
11 it's high. And if we're not going to apply any type of cost
12 sharing for dual eligibles, then logically we have to come
13 up with some other mechanism to deal with the potential
14 overuse or misallocation of resources for that very large
15 proportion of the population. And so if you follow the
16 logic that you have to come up with some other tool to
17 address the issue for 35 percent of the users of this
18 benefit, then the question is, Well, that tool, if it's
19 going to be effective for the dual eligibles, might that be
20 better than a co-pay or other form of cost sharing for the
21 non-duals? And that's something that comes up again and
22 again here, and I think we just kind of shovel it under the

1 rug and assume that, well, you can't charge duals anything
2 and so we have to have some other kind of tool, but we don't
3 spend a whole lot of time on what those tools are.

4 So I think that item 4 is -- that we're not ready
5 for prime time on making a recommendation for a specific
6 kind of change in policy. I really do think that we need to
7 think this thing through more carefully. In the perfect
8 world, I agree with Mike, this is something that you'd like
9 to do in terms of looking at the broader structure for the
10 program as a whole. I'm not opposed to going in for
11 something else if we had a strong consensus that we knew
12 what the something else is, and I just don't hear that
13 consensus.

14 And then, finally, I'd like to come back to this.
15 Evan, the reason I raised the question about improving
16 quality -- because I think quality of care really is at the
17 heart of this -- is that there's nothing on the slide -- and
18 I checked and I didn't see anything in the text -- about
19 what the case-mix -- in fact, whether it was case-mix-
20 adjusted at all or what that case-mix adjustment looked
21 like. So what I'd like to see is I'd like to see this chart
22 reproduced for values that are not case-mix-adjusted.

1 Kate followed up and raised the issue that I had,
2 which is a selection issue. If we think about the
3 population growing who are getting this benefit and it
4 starts from a very frail population becomes less frail, we
5 have the selection issue, you'd expect that all of these
6 indicators would be higher, and so if we were to compare the
7 adjusted and non-adjusted and see that we have very
8 different trends for the adjusted, then I'd be more sanguine
9 about saying, yeah, well, there really is improvement in
10 quality. But I'm not convinced on the face of it yet that
11 we know enough to say that there really is an improvement in
12 quality of care.

13 MR. HACKBARTH: Let me just pick up on Bruce's
14 comments about the co-pay. As I hear this conversation,
15 there are different potential rationales for looking at a
16 co-pay. One, and the reason that this is being discussed at
17 all, is that there are indications of potentially
18 significant overuse of the benefit, and having some amount
19 of co-pay might address that -- maybe not without collateral
20 problems, but that's the potential rationale.

21 As a number of people have pointed out, then you
22 start thinking about substitution questions and whether, you

1 know, we want people to go to the most efficient, and if you
2 put in the co-pay are we going to steer people away from a
3 potentially low-cost service into a higher-cost service, as
4 Mary was indicating. And, you know, that's a really
5 complicated question, and I'm not sure that any benefit
6 design can perfectly address the issues of substitution.
7 Those are really clinical judgments that, you know, you need
8 to make working with real live patients on the ground. No
9 benefit structure is going to be tweaked to the point where
10 you can get people making exactly the right decisions. You
11 can maybe get better, but it's going to be elusive.

12 The third rationale for looking at a co-pay for
13 this is it's one of the only services that doesn't have a
14 co-pay. We've got finite resources in Medicare, and as Bob
15 was pointing out, there's not a whole lot of rhyme or reason
16 to the way we distribute the burden among Medicare
17 beneficiaries, impose very heavy co-pays on hospitalized
18 patients that may have very little control over their
19 ability to use the services. And just as a matter of
20 equity, if we've got a finite amount of resources, we ought
21 to think about restructuring the benefits so that the burden
22 is shared more equitably at a high level, and in the

1 process, you know, introduce protections for low-income
2 beneficiaries and the like.

3 So, you know, we sort of bounce around among
4 potentially competing rationales for restructuring. The
5 more I listen to the conversation, the more I think that
6 maybe we need to talk about this as part of, you know, a
7 bigger discussion about the benefit package as opposed to in
8 isolation, even though I think we've got a serious problem
9 with overuse.

10 I'll just stop there.

11 DR. STUART: I just want to make clear: I am not
12 opposed to cost sharing.

13 MR. HACKBARTH: Yes.

14 DR. STUART: So my concern is more on the
15 technical grounds of whether this is going to have the
16 effect in terms of patient behavior that you want it to
17 have.

18 MR. HACKBARTH: Right.

19 DR. BAICKER: Yes, separating this out into the
20 patient side things and the provider side things, the co-
21 payment is the odd man out. And being the only one on the
22 patient side -- and in some ways you could unbundle that

1 into the same set of issues we're talking about on the
2 provider side. There's the level of co-payment. There is
3 the tilt in who should be paying more, who should be paying
4 less, which services, et cetera. And I'm strongly in favor
5 of co-payments. It seems both inefficient and inequitable
6 to have zero co-payment on this highly malleable service
7 when there are co-payments on things that are less
8 discretionary. And for all those reasons, I'd very much be
9 in favor of it, but I do think we probably need to unbundle
10 it into those different components the same way we're doing
11 on the provider side.

12 On the provider side things, I join everyone in
13 being firmly anti-fraud, so let's certainly do that first.

14 [Laughter.]

15 DR. BAICKER: That's right. I'm going to take a
16 bold stand here. Fraud is bad. And then thinking about --

17 DR. STUART: A tough decision.

18 DR. BAICKER: Yes. -- rebasing versus the
19 changing in case-mix, I was a little unclear on the
20 distinction that Peter was making in that I think of
21 rebasing plus change in case-mix as non-budget neutral
22 change in case-mix. You know, we're saying, okay, we're

1 going to tilt things and we're going to let the overall
2 level be dialed up or, in this case, down. And I'm favor of
3 both, and I don't know whether there's any advantage of
4 doing one first versus the other if the case-mix isn't quite
5 ready and the rebasing is. But I think of those together as
6 changing the mix of payments to people and changing the
7 total amount of money in the system at the same time. And
8 treating them as separate recommendations just seems like
9 decomposing that a little bit based on the availability of
10 the measures, and that seems fine to me.

11 As for the risk corridor one, it is a little
12 abstract for me to think about the particulars right not.
13 It seems to warrant further discussion.

14 DR. CASTELLANOS: Quickly, I'm in favor of all of
15 them. I strongly recommend the fraud and rebasing.
16 Rebasing is already in law for 2014.

17 Like Mike and like a lot of us, I like the concept
18 of co-pay. I'm a provider and I realize the value of co-pay
19 in the provider community. I think it needs a lot of work.

20 Like Bob, I think we should push on all five of
21 them at this time.

22 MS. HANSEN: Yes, I think the combination of the

1 rebasing, the case-mix, and the fraud are kind of a
2 coordinated campaign that can be done, and I think as
3 everybody is saying, the obvious one is the fraud one,
4 especially since we can work with the -- or really refer
5 this to the OIG, which actually gives a real important
6 signal, you know, to the broader community.

7 The co-pay discussion I think merits the kind of
8 discussion that other people have focused on. I am
9 definitely also supportive of some sense of co-pay.

10 And then it sounds to me that Recommendation 3,
11 which is the repeat or the Scanlon aspect, does really take
12 a lot of intellectual rigor and complexity of doing it. So
13 it's still worthy of doing it, but it just will require
14 perhaps some other people in the broader field to perhaps
15 focus on this kind of work that can inform us over time.
16 But bottom line, I think it's still very merit worthy but
17 very complex and requires a great of rigor to that.

18 MR. ARMSTRONG: Glenn, I just briefly would affirm
19 I support the direction for all five of the recommendations.

20 With respect to the sequencing question, I, too,
21 am like Bob. I'd do all five of them tomorrow if we could.
22 I recognize there are some issues that have been raised, in

1 particular on the co-pays, but I'm not uncomfortable with a
2 \$300 co-pay, but I recognize it's complicated issue. And I
3 really appreciated the way that you asked us to be cognizant
4 of the fact there are several different, sometimes
5 overlapping goals for implementing co-pays, and I think
6 clarity around that is good. But I just think the risk is
7 low enough that we shouldn't be too cautious about that in a
8 world where there are such -- where we're paying so much
9 more than what we're getting for through this program.

10 Then finally, to the point that was made by a
11 couple of people earlier about the supervision and the
12 recertification, I really believe that is worth some follow-
13 up discussion at some point, partly because -- actually,
14 probably mainly because I do see investments in home health
15 and the value of home health and the return to the Medicare
16 program at least to -- well, to a fairly large degree as an
17 investment in advancing the health of the patients as part
18 of a care system. And to the degree clinicians are
19 accountable for the patient's care, at least at some point
20 through that process or at various points through that
21 process, it increases the likelihood that their care in home
22 health is connected to a broader care plan for their health

1 in the broader sense.

2 So I know that's really not our topic for today,
3 but I think both Tom and Ron said that this would be a
4 worthy conversation for the future, and I would agree with
5 that.

6 DR. BORMAN: I'm generally supportive of the
7 package, and I share Bob and Scott's thoughts about moving
8 forward expeditiously. I do think that some -- more than
9 one of them raise issues -- or fall into the camp of the
10 more complicated vertical and horizontal and generational
11 and all inequities that we've talked about at points in the
12 past. I do think that I'm comfortable with carrying forward
13 number 3 because, as we carry forward many of our
14 recommendations that don't get implemented, I think there's
15 still a great deal of thought behind that. Nothing that we
16 do here particularly changes the somewhat vague nature of
17 what can be wonderful services under this umbrella, but it's
18 a very broad basket of services and not uniformly applied.
19 None of that changes that, and number 3 does speak to trying
20 to deal with that in the context of improving this.

21 So I think rebasing is going to happen. I think
22 the margins here suggest that it can happen sooner rather

1 than later without distinct harm to most, if not all,
2 beneficiaries. So that I think those things go together,
3 and if you have the rebasing -- I think the case-mix needs
4 to happen additionally, so no reason not to proceed forward
5 with that now. Number 3 is a carry forward. I think we do
6 need to endorse a co-pay. Frankly, it sounds almost to me
7 like it's a little bit -- what we've suggested is a little
8 bit more like a deductible because it isn't indexed to the
9 number of services and whatever. You know, but not being an
10 insurance glossary person, I may be out of my depth there.
11 But I think that we have endorsed the issues -- understand
12 the issues with first-dollar coverage. Our own work that
13 we've contracted out certainly supports some of those
14 issues. And I think we can make a recommendation with being
15 able to say that the specifics may require more work, that
16 we ourselves may want to commit that we will examine this in
17 this time frame; we may want to advocate some outsource or
18 whatever for that. But I think not to go on record as part
19 of this package that there should be a co-pay would be a
20 mistake, or whatever we want to call it. So, in general,
21 I'm supportive.

22 MR. HACKBARTH: We're at 10:12 right now, so we're

1 12 minutes behind. We've got to leave time for two more
2 presentations, so thank you, Evan.

3 Now we need to move on to inpatient rehab
4 facilities.

5 Christine, are you going first? Okay. Whenever
6 you're ready.

7 MS. AGUIAR: During this presentation, we will
8 discuss the adequacy of Medicare payments to inpatient
9 rehabilitation facilities, also referred to as IRFs. IRFs
10 provide intensive rehabilitation services, such as physical
11 and occupational therapy, to patients after an injury,
12 illness, or surgery. IRFs may be specialized units within
13 an acute care hospital or freestanding hospitals. About 80
14 percent of IRFs are hospital-based and 20 percent are
15 freestanding.

16 Medicare fee-for-service is the principal payer
17 for IRF services, accounting for about 60 percent of total
18 cases in 2009 and \$6 billion in spending. Since 2002, IRFs
19 have been paid on a per discharge basis, where rates vary
20 based on patients' conditions, wages, and certain facility
21 characteristics.

22 To qualify as an IRF, facilities must meet certain

1 criteria. IRF patients must require at least two types of
2 therapy, one of which must be physical or occupational
3 therapy. The patients must also generally need to tolerate
4 three hours of therapy per day for at least five days per
5 week. The facilities must meet the Medicare Conditions of
6 Participation for acute care hospitals and satisfy
7 additional criteria, such as having a medical director of
8 rehabilitation on a full-time basis, having a pre-admission
9 screening process for patients, and using a coordinated
10 interdisciplinary team approach led by a rehabilitation
11 physician.

12 In addition to the above criteria, IRFs must also
13 meet the compliance threshold, also known as the 60 percent
14 rule. The compliance threshold is important to understand
15 because of the impact that it had on many of the measures of
16 payment adequacy, so I will spend a few minutes to go over
17 it.

18 The compliance threshold is a requirement that
19 stipulates that no fewer than 60 percent of all IRF patients
20 have at least one of 13 conditions. The purpose of the
21 compliance threshold is to distinguish IRFs from acute care
22 hospitals, and the 13 conditions are diagnoses that

1 typically require intensive in-hospital rehabilitation.

2 Enforcement of the compliance threshold was renewed in 2004.

3 Also in 2004, CMS limited the types of major joint
4 replacement patients that counted toward the threshold.

5 Major joint replacements, such as hip and knee replacements,
6 were commonly treated in IRFs before 2004. The combination
7 of most of those patients not counting towards the threshold
8 and renewed enforcement of the threshold resulted in a
9 substantial decline in volume after 2004. As volume
10 declined, occupancy rates and the number of rehabilitation
11 beds fell, as well. Case-mix increased as the IRF patient
12 population shifted to more severe patients that counted
13 towards the threshold. Growth in cost per case also
14 increased, as fixed costs were spread across fewer patients.

15 The compliance threshold was originally set at 75
16 percent. However, it was permanently capped at 60 percent
17 in 2007. Since then, the industry has begun to stabilize in
18 its response to the compliance threshold, as we will see in
19 the following slides.

20 Just as a quick reminder, we use the same
21 framework for payment adequacy as we use in other sectors.

22 I will now begin discussing our measures of access

1 to care. On this chart, you see the supply of IRFs from
2 2002 to 2009. Supply peaked in 2005 and decreased after
3 that. In 2009, changes in supply varied by category of
4 provider, with the overall picture suggesting that the
5 supply of IRFs is stabilizing. The categories with the
6 highest growth are freestanding and rural IRFs. Growth in
7 rural IRFs occurred among hospital-based IRFs. There is at
8 least one IRF located in every State, although IRFs are not
9 evenly distributed among States. However, because other
10 Medicare providers, such as skilled nursing facilities and
11 home health agencies, also provide rehabilitation services,
12 it is unlikely that many areas exist where IRFs are the only
13 therapy provider available to beneficiaries.

14 Occupancy rates are one measure of provider
15 capacity. Occupancy rates have been falling since 2002 and
16 fell at a higher rate in 2004 when enforcement of the
17 compliance threshold was renewed. In 2009, occupancy rates
18 remain relatively stable, increasing slightly for both
19 freestanding and hospital-based IRFs, although occupancy was
20 higher for freestanding IRFs. The occupancy rate across all
21 IRFs was 62.8 percent in 2009, which indicates that capacity
22 is adequate to handle current demand and IRFs can likely

1 accommodate future increases.

2 The number of rehabilitation beds is another
3 measure of capacity. The number of IRF beds declined by an
4 average of 1.1 percent each year between 2004 and 2008, as
5 IRFs adjusted to a decrease in cases due to renewed
6 enforcement of the compliance threshold. In 2009, the total
7 number of IRF beds decreased slightly, by 0.3 percent, the
8 result of a decrease in hospital-based IRF beds and an
9 increase in freestanding IRF beds.

10 This chart presents fee-for-service spending on
11 IRFs, the number of fee-for-service cases, and fee-for-
12 service payment per case from 2002 through 2009. As you can
13 see, the number of IRF cases declined after 2004 when
14 enforcement of the compliance threshold was renewed.
15 However, volume began to stabilize in 2008 after the
16 compliance threshold was capped at 60 percent. In 2009,
17 volume remained relatively stable, with the number of cases
18 increasing by 1.5 percent. The increase in the number of
19 cases from 2008 to 2009 was due to an increase in both the
20 number of unique beneficiaries receiving IRF care and an
21 increase in the number of beneficiaries with more than one
22 IRF stay in a year. The average fee-for-service payment per

1 case declined by half-a-percent between 2008 and 2009
2 because payments in 2009 were held at 2007 levels.

3 We also analyzed IRF patient mix, which has
4 changed since 2004 as IRFs adjusted to meet the compliance
5 threshold. As expected, the share of cases with conditions
6 that count towards the compliance threshold has increased.
7 For example, the share of stroke patients, shown on the
8 graph in orange, increased by 3.9 percentage points between
9 2004 and 2010. Also, as expected, the share of major joint
10 replacement cases, shown here in red, have fallen since 2004
11 when CMS limited the types of these cases that count towards
12 the compliance threshold. Case-mix also increased as the
13 patient mix increased, and between 2008 and 2009, case-mix
14 grew by 2.3 percent.

15 We also analyzed changes in acute care hospital
16 discharge destinations from 2004 to 2010 for hip and knee
17 replacement patients to assess whether the compliance
18 threshold impacted these beneficiaries' access to care. As
19 you can see, acute care discharges to IRFs for hip and knee
20 replacements declined by 15 percentage points between 2004
21 and 2009. However, discharges to skilled nursing facilities
22 and home health agencies increased over the same period by

1 four and ten percentage points, respectively. Beneficiaries
2 with hip and knee replacements that were previously treated
3 in IRFs were able to receive rehabilitation services in
4 other settings.

5 Now we will move on to two more payment adequacy
6 measures, quality of care and access to capital. We measure
7 quality by the difference between functional status from
8 admission and discharge. Between 2004 and 2010, the gain in
9 functional status increased 3.3 points for all fee-for-
10 service patients. However, over the same time period, the
11 functional status at admission declined because IRFs
12 admitted more severely impaired cases that met the
13 compliance thresholds. Currently, we cannot conclude
14 whether the gain in functional status between admission and
15 discharge is due to an improvement in quality or due to the
16 declining functional status at admission.

17 Also, with respect to IRF quality measurement, the
18 Patient Protection and Affordable Care Act requires IRFs to
19 begin submitting quality measures in fiscal year 2014. We
20 recently held a meeting with rehabilitation clinicians,
21 researchers, and IRF medical directors to discuss the types
22 of measures that IRFs should be required to report. I will

1 present the results of that meeting during the January
2 presentation.

3 Access to capital is another measure of payment
4 adequacy. Hospital-based units have access to capital
5 through their parent institution, and as we heard during the
6 inpatient hospital presentation yesterday, hospitals' access
7 to capital appears adequate. Therefore, it is likely the
8 hospital-based IRF units have adequate access to capital.

9 To measure access to capital for freestanding
10 facilities, we review access to the credit markets for two
11 major national chains. These chains continue to experience
12 positive revenue growth and are able to access the capital
13 markets.

14 We will now move on to measures of Medicare
15 payments and providers' costs. This graph displays growth
16 in payments and costs per case since 2002. Payments per
17 case have grown faster than cost per case since the
18 implementation of the PPS in 2002. In 2004, the gap between
19 the growth of payments and costs began to close when volume
20 declined due to renewed enforcement of the compliance
21 threshold and the limitation on the major joint replacement
22 patients that counted towards the threshold. With the lower

1 volume of fee-for-service patients, fixed costs were spread
2 over a smaller number of cases and growth in cost per case
3 accelerated.

4 Adjusting IRF costs per case for differences in
5 wages, case-mix, and outlier payments permits a standardized
6 comparison of costs across different types of IRFs. This
7 table displays the characteristics of IRFs in the low- and
8 high-cost quartiles of adjusted cost per case. This data
9 permits us to begin constructing the profile of efficient
10 IRF providers. While we cannot identify efficient providers
11 without risk-adjusted quality measures, we can begin to see
12 patterns in efficiencies with costs.

13 Larger bed size and higher occupancy rates are
14 characteristics of IRFs in the low-cost quartile. The
15 median bed size decreased from 37 beds in the low-cost
16 quartile to 18 beds in the high-cost quartile. Occupancy
17 rates also decrease across quartiles, with the average
18 occupancy rate for IRFs in the low-cost quartile approaching
19 70 percent, while IRFs in the high-cost quartile are, on
20 average, at half occupancy. Given that freestanding IRFs
21 are more likely to be larger facilities and to have higher
22 occupancy rates, it is not surprising that these facilities

1 are more likely to be in the low-cost quartile.

2 Case-mix does not vary by much across quartiles,
3 suggesting that it is not case-mix but rather bed size and
4 occupancy rates that are more indicative of lower cost per
5 case.

6 This chart shows the Medicare margins for IRFs.
7 IRF margins declined between 2008 and 2009, but remained a
8 healthy 8.4 percent across the industry. The margin decline
9 in 2009 is expected because 2009 payment rates were frozen
10 at 2007 levels.

11 Margins vary across providers. Urban IRFs have
12 higher margins than rural IRFs. However, the 18.4 percent
13 rural adjustment factor contributes to the close margins for
14 urban and rural providers.

15 Freestanding IRFs have substantially higher
16 margins than hospital-based IRFs, and the difference between
17 freestanding and hospital-based IRF margins grew larger in
18 2009. While freestanding IRF margins increased in 2009 to
19 20 percent, despite not having a payment update for that
20 year, hospital-based IRF margins declined to point-five
21 percent. The difference in margins between freestanding and
22 hospital-based IRFs is likely due to the ability to manage

1 costs, which we will see on the next slide, and due to
2 economies of scale. Hospital-based units, in general, have
3 fewer beds than freestanding facilities and have lower
4 occupancy rates.

5 To illustrate the difference in freestanding and
6 hospital-based IRFs' abilities to manage costs, this graph
7 shows the growth in cost per case for hospital-based IRFs,
8 represented in the red bars, and freestanding IRFs,
9 represented in the yellow bars. Growth in average cost per
10 case for freestanding and hospital-based IRFs peaked in
11 2005, as the industry managed a decline in volume due to
12 renewed enforcement of the compliance threshold. However,
13 after 2005, freestanding IRFs were able to lower the growth
14 in cost per case while cost per case continued to grow at
15 higher rates for hospital-based IRFs.

16 As we have seen, aggregate Medicare margins for
17 IRFs in 2009 were 8.4 percent. To project the aggregate
18 Medicare margin for 2011, we modeled the following policy
19 changes for 2010 and 2011. Market basket minus 2.5 percent,
20 as specified in PPACA, for 2010 and 2011, and an adjustment
21 to the outlier threshold in 2011 that CMS estimated will
22 slightly reduce IRF payments. We estimate that Medicare

1 margins for 2011 will be 8.1 percent.

2 In summary, our indicators of payment adequacy for
3 IRFs are generally positive. Supply and capacity are stable
4 and adequate to meet demand. With the compliance threshold
5 permanently set at 60 percent, the decline in volume since
6 2004 tapered off, and volume remains stable in 2009. We
7 have seen an increase in functional gain, which suggests
8 improved quality. However, we cannot conclude definitively
9 without risk adjustment. Access to credit appears adequate
10 for hospital-based and freestanding IRFs. Finally, we
11 project the 2011 aggregate Medicare margins to be 8.1
12 percent, down slightly from the 8.4 percent margins in 2009.
13 To the extent that IRFs restrain their cost growth, the
14 projected 2011 margin could be higher than we have
15 estimated.

16 The Chairman's draft recommendation for your view
17 is: "The Congress should eliminate the update to the
18 payment rates for inpatient rehabilitation facilities for
19 fiscal year 2012." On the basis of our analysis, we believe
20 that IRFs could absorb cost increases and continue to
21 provide care with no update to the payments in 2012. We
22 estimate that this recommendation will decrease Federal

1 program spending relative to current law. We do not expect
2 this recommendation to have adverse impacts on Medicare
3 beneficiaries. This recommendation may increase the
4 financial pressure on some providers, but overall, a minimal
5 effect on providers' willingness and ability to care for the
6 Medicare beneficiaries is expected.

7 This concludes the presentation and I welcome any
8 questions.

9 MR. HACKBARTH: Thank you, Christine. Well done.

10 We have 35 minutes for discussion, and so I think
11 we're starting with Karen this time. Clarifying questions.
12 Scott?

13 MR. ARMSTRONG: In some of the other sections,
14 we've seen margins for hospital-based programs lower in part
15 because of the higher overhead expenses, the burden that
16 they're carrying. Is that part of what explains the
17 differential margins for the hospital-based IRFs?

18 MS. AGUIAR: Sure. I'll take a crack at it, and
19 then Craig, who's more familiar with the margins, could
20 elaborate. I believe, especially with the hospital-based
21 margins, we see a relationships with bed size which
22 indicates that there is an economy of scale. And so of the

1 providers that have the bed size in the one-to-ten range,
2 about 99 percent of them are hospital-based. The majority
3 of hospital-based have between -- have less than 60 beds,
4 whereas the higher percent -- about half of freestanding
5 facilities have 60 or more beds. So there is that
6 relationship in the margins there with economies of scale.

7 MR. LISK: Yes . You have to think the economies
8 of scale is really the major factor here rather than the
9 overhead is. You have to think as one of the requirements
10 is having a full-time director of rehabilitation. So you
11 divide that over ten beds, your cost is going to be a lot
12 higher per bed for that expense versus a place with 60 beds,
13 which may have more than just one person related to that.

14 But the other thing is when you look at the
15 occupancy rate, too, is there are differences, the lower
16 occupancy rate in the hospital-based versus the
17 freestanding, too.

18 DR. CASTELLANOS: I'm not sure if this is
19 appropriate at this time, but first of all, I support this.
20 I think there's a real value. One of the criteria to get
21 into the rehabilitation for the patient is he or she must be
22 able to undergo three hours a day, right. Why is that just

1 for five days a week and not on weekends?

2 MS. AGUIAR: I'm not sure that it's not on
3 weekends. I believe it's three hours a day for five days
4 per week, and when you have -- do you want to elaborate on
5 this?

6 MR. LISK: It was clarified more recently that
7 it's for five days a week, and in fact, sometimes people
8 need rest for their therapy, so they need some break. But
9 it is -- I think that's something that has been, like,
10 clarified recently. We can get back to you more
11 specifically on that, but --

12 MS. AGUIAR: Yes --

13 DR. CASTELLANOS: I'd really like you to get back
14 to me.

15 MS. AGUIAR: Yes, we will get back, and what it is
16 is that therapy has to begin, I believe, within 36 hours,
17 depending -- even if that person started on a weekend. So
18 when they were admitted to the IRF is when that sort of
19 clock starts, and then it has to begin, I believe, within 36
20 hours from them and then has to be at least, you know, three
21 hours a day for five days. But we'll get back to you --

22 DR. CASTELLANOS: Thank you.

1 MR. LISK: The other thing, I think, is it's not
2 35 hours a week, and I think there was some indication from
3 the industry that it wants to go to it being 35 hours a
4 week, or maybe I did my math wrong, but -- but anyway --

5 DR. CASTELLANOS: Get back to me.

6 MR. HACKBARTH: Jennie, did I skip over you?
7 Okay. Kate, clarifying question, Bruce, Nancy.

8 DR. KANE: Yes. It would be -- I know we had
9 something in the paper about the MA plan use of IRFs. It
10 would also be interested to look at the non-Medicare margins
11 for this sector, just to get a sense of how far differently
12 Medicare is to others, because this is an -- unlike home
13 health, it actually has capital requirements, and so when
14 you look at a profit margin, it's not the same kind of
15 profit margin as when you're looking at home health and it
16 would be better -- it would be kind of good to see how far
17 off or close we are as we start to say, let's get those
18 profits down. Now, I don't think they had a big problem
19 when it was up around 14 percent, or even maybe eight
20 percent. I don't know. But not having any sense of what
21 the overall profitability is or the capital requirements
22 means we're just picking a number for the profit side. So

1 do we have any sense of their non-Medicare profitability?

2 MR. LISK: If I look at the total margin for the
3 freestanding facilities, because it's more difficult to
4 separate that out on the hospital-based, the total margin on
5 the freestanding is a little bit lower than what it is for
6 what Medicare is paying --

7 DR. KANE: So we're overpaying relative to what
8 the private sector and Medicaid might be paying.

9 MR. LISK: That --

10 DR. KANE: Or Medicare is paying.

11 MR. LISK: -- might be the implication on the
12 freestanding. I don't know what it comes out to on the
13 hospital-based side.

14 DR. KANE: Okay. My only other question is, do we
15 have a sense -- in 2009, I notice the freestandings actually
16 lowered their cost per case. Do we have a sense of how they
17 did that?

18 MS. AGUIAR: I have asked one of the
19 representatives who sort of was doing exceptionally well
20 with their margins, but I do think I should probably go back
21 and ask more providers to get sort of a broader -- I would
22 rather go back and ask them again before I report back to

1 you on that.

2 DR. KANE: If there are any quality measures, it
3 would be kind of nice to see how that goes along with what
4 happens with the cost changes.

5 MS. AGUIAR: Yes.

6 DR. BERENSON: Yes. I have a data question and
7 the easiest way to deal with it is to read two sentences
8 from the paper. It wasn't in your presentation here. "In
9 the first three years of renewed enforcement of the
10 compliance threshold, 2004 to 2006, the aggregate percent of
11 Medicare cases meeting the threshold increased rapidly from
12 45 to 60.1 percent. However, when Congress capped the
13 threshold permanently at 60 percent in 2007, the compliance
14 rate began to level off and it has remained between 61 and
15 63 percent."

16 I find it remarkable that the threshold level is
17 the same as the average. I would have thought that a bunch
18 would have rates at 70 or 75. Is this, one, correct, and
19 two, are IRFs able to titrate their admissions so that
20 they're all coming in at 60 percent?

21 MS. AGUIAR: We do get this data from eRehabData,
22 and unfortunately, they don't have a complete sample of all

1 of the IRFs. Specifically, they're missing the largest
2 freestanding IRF provider, which accounts for 20 percent of
3 total revenues and 50 percent of all freestanding and for-
4 profit revenues. So there is somewhat of a limitation.
5 That aside, this data -- it has been consistent. We've been
6 seeing this consistent trend previously, so we don't have
7 any reason to think that that's not true.

8 What it indicates, sort of what it suggests is
9 that they were reaching -- they were going towards having to
10 comply for a 75 percent threshold, because originally when
11 CMS -- in 2004, when they renewed enforcement of the
12 compliance threshold, it was set at 75 percent and there was
13 a four- or five-year, I believe, phase-in period to that.
14 Then in 2007, it was capped permanently at 60 percent. So
15 it seemed like they were reaching to meet that 75 percent
16 threshold, and then once it was stuck at 60 percent, their
17 compliance rate has been hovering around there.

18 DR. BERENSON: It wasn't clear. What happens to
19 an IRF that doesn't meet the compliance rate?

20 MS. AGUIAR: I believe that they are not allowed --
21 they don't receive payment, I believe --

22 MR. LISK: They become no longer an IRF and they

1 become a PPS hospital --

2 MS. AGUIAR: Yes.

3 MR. LISK: -- and so they would be paid under PPS,
4 which --

5 DR. BERENSON: The incentive is to make 60
6 percent, but not more than 60 percent.

7 MS. AGUIAR: Right. Exactly.

8 DR. CHERNEW: Can you just remind me what the
9 copay is on an IRF stay?

10 MS. AGUIAR: It's the hospital inpatient copay. I
11 believe it's \$1,200, and it's only for patients that are
12 admitted from the community, the community admits.

13 MR. HACKBARTH: So somebody is transferred after
14 an acute inpatient stay, it's zero.

15 MS. AGUIAR: Right. Exactly. But they do have,
16 after a certain number of days, they have a copay.

17 MR. LISK: Yes, if they exceed the Medicare limits
18 on stays, then there is those --

19 DR. CHERNEW: Right.

20 MS. AGUIAR: Right.

21 DR. CHERNEW: But if you had a hip or a knee
22 replacement and you were deciding between an IRF or home

1 care, the IRF copay is \$1,200, or you might not be in the
2 community, so I'm not sure exactly how this would work, but
3 just conceptually. The home care, which you showed on one
4 of your slides the substitutability --

5 MS. AGUIAR: Right.

6 DR. CHERNEW: -- it now would be zero. Home care
7 would be free and the IRF would be \$1,200.

8 MS. AGUIAR: Right --

9 MR. HACKBARTH: [Off microphone.] -- patient
10 surgery.

11 MS. AGUIAR: Exactly.

12 DR. CHERNEW: [Off microphone.]

13 MR. HACKBARTH: So if they had a knee replacement
14 or a hip replacement, that would be -- I think it's still
15 inpatient --

16 MS. AGUIAR: Exactly.

17 MR. HACKBARTH: -- and so when they were
18 transferred to the IRF, the copay would be zero.

19 MS. AGUIAR: Right. They wouldn't have the copay --
20 -

21 MR. HACKBARTH: And if they went home, it would be
22 zero.

1 DR. MARK MILLER: And what's happening here is
2 there's a \$1,000 copayment on hospital -- or deductible on
3 hospitalization, right?

4 MS. AGUIAR: Yes.

5 DR. MARK MILLER: That's what we're talking about
6 here. And this is considered a continuation of the
7 hospitalization, is that the point?

8 MS. AGUIAR: Yes. Exactly.

9 MR. BUTLER: All right. I have several slides to
10 walk through to see if I can understand --

11 DR. MARK MILLER: [Off microphone.] I'm sorry.
12 Just to stay on his point for one second, in the
13 circumstances where somebody comes from the community,
14 however --

15 MS. AGUIAR: Yes, that's correct.

16 DR. MARK MILLER: -- it's as if they pay a \$1,000
17 deductible on a hospitalization, except they would be going
18 to the IRF. And so in that instance, your point --

19 DR. CHERNEW: I don't mean to go across
20 presentations, recognizing that would be too silo-breaking,
21 but --

22 [Laughter.]

1 DR. CHERNEW: -- we were talking about a copay in
2 the other one --

3 DR. MARK MILLER: I know.

4 DR. CHERNEW: -- and this is a substitute service,
5 as you can see from Slide, whichever one -- Slide 10 shows
6 you there's some substitutability between home health, up
7 ten, IRF, down 15 percent. And so it strikes me as a
8 potential thing that someone might be interested in, the
9 copay symmetry. That was the only reason why I wanted to
10 know.

11 MR. HACKBARTH: Absolutely. Do we know -- do you
12 know off the top of your head what the percentage of
13 admissions to IRFs come after an acute in-hospital stay as
14 opposed to from the community?

15 MS. AGUIAR: I could get you the exact number. I
16 believe it's less than three percent that come from the
17 community to the IRFs.

18 MR. HACKBARTH: Right. So typically, it's going
19 to be zero.

20 DR. STUART: But I believe the law on episode of
21 illness would allow up to a 30-day or 29-day gap between the
22 discharge from a hospital and an admission to an IRF would

1 be a continuous stay. So it might not -- so it depends on
2 how you've looked at the relationship between discharge and
3 admission. I mean, there could be a gap and it still would
4 not generate the deductible.

5 MR. HACKBARTH: Okay. Peter, you're up.

6 MR. BUTLER: So I've understood in the past the
7 differences in the hospital-based SNFs and home health and
8 why the numbers don't add up here, and I understand the
9 baseline on this and the different -- the economies of scale
10 question. I clearly understand why there could be a
11 difference. What I don't understand is the trend. One of
12 your slides, and you're going back to 2004, so there's been
13 relatively stable occupancy for both the freestanding as
14 well as the hospital-based, modest declines in both. But
15 the headlines is stable occupancy rate. So it's not like
16 one has declined and the other hasn't.

17 So now go to Slide 16 and you say the main reason
18 for the decline of 12 percent down to point-five percent in
19 the hospital-based profitability, which has not occurred on
20 the other side, is the growth in cost, and this slide
21 clearly demonstrates that. It shows, though, in those
22 earlier years that apparently the hospital-based folks could

1 manage the costs as well as the freestanding and suddenly
2 they lost their -- they couldn't do it anymore, even though
3 their occupancy didn't decline. It just -- it doesn't kind
4 of make sense to me that this is just a, suddenly, something
5 happened there.

6 So I come back to, do we have a change in the mix
7 of patients, which is always Glenn's argument. If you can
8 say that, then you can justify a difference in a rate
9 increase or a rate amount.

10 So now go back to Slide 9, and I realize we're
11 sitting here with one month before we're going to vote on
12 something, so I don't know that we can get answers to this
13 trend, but it is pretty striking that one would go up so
14 much more than the others. I kind of wonder if this profile
15 would look different in the hospital-based versus the
16 freestanding, so that the mapping -- not that stroke, and
17 these are measures of case-mix, but it would tell something
18 about the underlying trend that would help explain the --
19 because I don't think management of the costs is
20 significantly different in the two enterprises. I think we
21 do have a mix thing going on. I don't know that we can
22 quantify it, but I wanted to highlight that and see if

1 there's some way to kind of, just as the earlier question
2 was how did they reduce their costs, I'm skeptical something
3 else is going on.

4 MR. HACKBARTH: Interesting question, so
5 Christine, have you looked at this? Have you done this
6 graph for hospital-based versus freestanding?

7 MS. AGUIAR: No, I haven't, and I have to look to
8 see if we are able to with this data source.

9 MR. HACKBARTH: Okay.

10 MS. AGUIAR: I have to look into it, and if we can,
11 then I'll definitely produce that for you.

12 MR. HACKBARTH: Okay. So then turn to the graph
13 on page 16. Do you have any hypotheses in response to
14 Peter's question about why the marked difference in the
15 trend on hospital-based versus freestanding?

16 MS. AGUIAR: So, I mean, I'm speculating at this
17 point. What it seems to me is that both hospital-based and
18 freestanding were both under some of the same pressures and
19 responding to the 60 percent rule -- I'm sorry, to the
20 compliance threshold, which was reinforced in 2004, and so
21 which is why I think you saw a volume decline and a decline
22 in occupancy rates and beds across for both.

1 And then it seems to me what this sort of implies
2 is that the freestanding, which do tend to be larger and to
3 have higher occupancy rates in general than the hospital-
4 based facilities, were more able to control their cost
5 growth, were more able to respond to the compliance
6 threshold and therefore were just more effective at doing
7 so.

8 The question of whether or not the patient mix and
9 the case-mix is different, we haven't looked at that. So
10 I'm going to check back to see if we can check into that. I
11 think the one thing to keep in mind here is that the
12 freestanding is dominated by one chain in particular who has
13 50 percent of freestanding revenues, and that chain, their
14 margins are even higher. They're about 25 percent margins.
15 So they are doing exceptionally well. They're doing better
16 even sort of than you would expect if there was no payment
17 cut in 2008 and 2009. So the freestanding numbers are also
18 brought up by that company specifically.

19 MR. HACKBARTH: Yes.

20 MS. AGUIAR: And I think, you know, when we
21 stratified the results of cost per discharge by the low cost
22 -- when we standardized them, looked at low cost and high

1 cost, you sort of saw some of the same story. It's, like,
2 higher occupancy rates, higher number of beds, of course,
3 more likely to be freestanding is what sort of pushes you in
4 the efficiency with managing your costs category.

5 MR. HACKBARTH: Yes. So let me ask this. I think
6 that the decline in admissions was similar between the
7 hospital-based and freestanding -- I'm a lawyer, I'm not a
8 mathematician. Because of the smaller size of the hospital-
9 based, any given decline in occupancy would have more of an
10 effect on their year-to-year change in costs than it would
11 for a larger institution, is that right?

12 MS. AGUIAR: Right, I think.

13 MR. BUTLER: The Slide 4 shows that the declines
14 in occupancy was very modest and similar. I mean, it's not
15 -- I wouldn't think it would explain all of that.

16 MR. HACKBARTH: Okay.

17 DR. MARK MILLER: The other thing here is we've --
18 and I don't know at least half of what I'm going to suggest,
19 but there's also we've been tracking hospital cost growth
20 and during that period it was a lot more rapid than the
21 market basket. That's some of the discussions we've had in
22 the hospital world about their cost relative to their input

1 cost. And I don't know what the cost growth has been on the
2 IRF side. mean, we've been sort of making this argument
3 that the hospital cost growth is not under the same kind of
4 pressure because of the payment on the private sector side,
5 and so I'm trying to figure out whether freestanding IRF
6 cost growth is slower than the cost growth we've seen in the
7 hospital sector.

8 MR. HACKBARTH: So you --

9 MR. LISK: Actually, can I add a piece of
10 information that may be somewhat helpful? We can try to see
11 whether we can go back and do what Christine is talking
12 about in the analysis, but again, it's one large chain. So
13 they're freestanding, so this will be a differential. But
14 they did indicate they weren't as impacted as much by the 60
15 percent rule or the 75 percent rule because they did not do
16 as much on the hip and knee replacements, for instance. And
17 I think hospitals had a lot -- many hospitals had a lot more
18 of those and had to adjust for those. So there could have
19 been a bigger shift and change in the case-mix there, but
20 that's what we need to go back and check. But that is one
21 possibility, what we're seeing there. It's one reason for
22 the differential.

1 MR. HACKBARTH: So you understand the gist of the
2 issue that Peter is raising.

3 MS. AGUIAR: Yes.

4 MR. HACKBARTH: Let's see if we can bring some
5 analysis to bear.

6 Mary, any clarifying? Tom? Mitra?

7 Okay. Round 2 comments. Karen?

8 DR. BORMAN: I generally support the
9 recommendation.

10 MR. ARMSTRONG: I also support the recommendation.

11 MS. HANSEN: I support.

12 DR. CASTELLANOS: I'd support.

13 DR. BAICKER: I support it, as well.

14 DR. STUART: I support it.

15 MR. GEORGE MILLER: Aye.

16 DR. CHERNEW: Aye.

17 MR. BUTLER: Subject to understanding if there's a
18 case-mix change or not, I would like to understand that.

19 DR. NAYLOR: [Off microphone.] Aye.

20 DR. DEAN: Yes, I would support the
21 recommendation. It just strikes me, to compare this
22 discussion and these data with the ones we saw previously,

1 it seems to me that in this situation and this service, we,
2 correctly or incorrectly, we've been able to define the
3 benefit in a more precise way and it looks like utilization
4 is under reasonable control. I think there's maybe a lesson
5 there for our previous discussion.

6 MS. BEHROOZI: Starting with the one "unless," the
7 margins are high enough, so I support the recommendation.

8 MR. HACKBARTH: All right. Thank you very much.

9 [Pause.]

10 MR. HACKBARTH: So we are now to our final
11 presentation on long-term care hospital services. And,
12 Dana, you can start whenever ready.

13 MS. KELLEY: Good morning. So turning to our
14 long-term care hospital update, you are well familiar with
15 the update framework by this point, so I'll just start with
16 a little bit of background on LTCHs to refresh your memory.

17 Patients with clinically complex problems who need
18 hospital care for relatively extended periods are sometimes
19 treated in LTCHs. To qualify as an LTCH under Medicare, a
20 facility must meet Medicare's conditions of participation
21 for acute care hospitals and have an average length of stay
22 greater than 25 days for its Medicare patients.

1 Due to these long stays and the level of care
2 provided, care in LTCHs is expensive, averaging \$37,500 per
3 case in 2009. Medicare pays LTCHs under a per-discharge PPS
4 and the LTCH PPS uses the same MS DRGs as are used in the
5 acute care hospital PPS, but with weights that are specific
6 to LTCHs.

7 For some patients, payments are adjusted to be
8 more in line with those for similar patients in acute care
9 hospitals, and I'll talk a little bit more about that in a
10 minute.

11 Following implementation of the PPS in fiscal year
12 2003, Medicare spending for LTCH services grew rapidly,
13 climbing an average of 29 percent per year between 2003 and
14 2005. This growth prompted concerns about the demand for
15 LTCH care, patient selection, and the possible unbundling of
16 services from the acute care PPS.

17 As a result, CMS implemented regulations such as
18 the 25 percent rule, which reduces payments for hospitals
19 within hospitals if they admit a certain share of their
20 patients from their host hospitals. Between 2005 and 2008,
21 growth in spending slowed to less than 1 percent per year.

22 After Congress rolled back or delayed

1 implementation of some of CMS's regulations in the Medicare,
2 Medicaid, and CHIP Extension Act of 2007, spending for LTCH
3 services began to climb again, as you can see here, rising
4 6.4 percent between '08 and '09, to reach \$4.9 billion.

5 I'm going to quickly review changes to LTCH
6 payment policies that were wrought by MMSI and subsequent
7 amendments as well as by the Affordable Care Act, because so
8 many of them affect factors we consider in our update
9 framework.

10 First, as I mentioned, Congress delayed the phase-
11 in of the 25 percent rule, as well as reductions in payment
12 for LTCH cases with the very shortest lengths of stay.
13 Second, in exchange for this regulatory relief, the industry
14 faces a moratorium on new LTCHs and new LTCH beds through
15 December 2012.

16 Third, Congress mandated that CMS report on the
17 use of facility and patient criteria for LTCHs. You'll
18 remember that this is something the Commission recommended
19 back in 2004. The report from CMS was due July 2009, but as
20 of today is still pending.

21 The fourth bullet here refers to PPACA as mandated
22 reductions and updates to the LTCH payment rates. PPACA

1 required CMS to reduce the update by a quarter point for the
2 second half of fiscal year 2010 and by a half point for
3 fiscal year 2011. And then finally, PPACA mandates that CMS
4 implement a pay-for-reporting program for LTCHs by October
5 2013.

6 You'll recall that LTCHs don't submit any quality
7 data to CMS. In October, staff convened a panel to provide
8 input on the development of quality measures, and I'm going
9 to go ahead and present our update findings, and then report
10 on the findings from the panel.

11 So turning now to our update framework, our first
12 consideration is access to care. We have no direct
13 indicators of beneficiaries access to LTCH services, so we focus on
14 changes in capacity and use. But it's important to keep in
15 mind that, as a previous service we've discussed this
16 morning, the product is not well-defined.

17 There are not established criteria for admission
18 to an LTCH so it's not clear whether the patients treated
19 there require that level of care. And remember that many
20 Medicare beneficiaries live in areas without LTCHs and so,
21 presumably, are receiving similar services in other
22 facilities.

1 So to gauge access to services we'll first look at
2 available capacity, and you can see here the number of LTCHs
3 in the U.S. From the early '90s, which isn't shown in this
4 slide, but up until 2005, the number of LTCHs quadrupled.
5 Growth in the number of LTCHs leveled off between 2005 and
6 2008, that period when CMS implemented the payment
7 regulations that limited the growth in the spending.

8 As we've seen, spending began to climb again
9 between '08 and '09, and the number of LTCHs did as well,
10 rising 6.6 percent. This was surprising to some observers
11 because the moratorium Congress imposed -- because of the
12 moratorium that Congress imposed beginning in July 2007.
13 But exceptions to the moratorium were made for LTCHs that
14 were already in the construction pipeline and that exception
15 allowed this influx in facilities that we've seen.
16 Preliminary analysis suggests that far fewer LTCHs opened in
17 2010.

18 The rate of growth in the number of LTCH beds
19 picked up between '08 and '09 as well, and nationwide, in
20 2009, there were about 27,000 certified LTCH beds. This
21 shows growth in the number of cases per 10,000 fee-for-
22 service beneficiaries and we can see a slight increase over

1 the past few years after a period of rapid growth. So taken
2 together, these trends suggest to us that access to care has
3 been maintained during the period.

4 Turning now to quality, as I said, LTCHs don't
5 submit quality data to CMS so we rely on trends and in-
6 facility mortality, mortality within 30 days of discharge,
7 and readmission to acute care to assess gross changes in the
8 quality of care in LTCHs. In 2009, these rates were stable
9 or declining for most of the top 20 diagnoses.

10 Access to capital, as you know, allows LTCHs to
11 maintain and modernize their facilities. If LTCHs were
12 unable to access capital, it might, in part, reflect
13 problems with the adequacy of Medicare payments since
14 Medicare provides about two-thirds of LTCH revenues,
15 typically.

16 In 2010, the three largest LTCH chains, which
17 together own slightly more than half of all LTCHs, continued
18 with construction of new LTCHs that were already in the
19 pipeline, and thus exempt from the moratorium on new
20 facilities. In addition, these chains acquired other LTCHs
21 and other PAC providers.

22 According to the chains' filings with the SEC, all

1 three have access to revolving credit facilities that
2 they've tapped to finance these acquisitions. LTCH
3 companies are increasingly diversified, both horizontally
4 and vertically, which may improve their ability to control
5 costs and better position the companies for payment policy
6 changes.

7 Nevertheless, policy makers' increased scrutiny of
8 LTCH spending and quality has heightened investor anxiety
9 about the industry, and some analysts consider it to be one
10 of the most risky of the health care provider settings.
11 Smaller chains and non-chain facilities have more difficulty
12 accessing capital, but also are more likely to be limited by
13 the moratorium.

14 How have LTCHs per case payments compared to per
15 case costs? In the first years of the PPS, LTCHs appeared
16 to be very responsive to changes in their payments,
17 adjusting their costs per case when payments per case
18 changed. Payment per case increased rapidly after the PPS
19 was implemented, climbing an average of 16.6 percent per
20 year between '03 and '05.

21 Much of this growth was due to improvements in the
22 documentation and coding of patients following the

1 implementation of the new classification system. During
2 this early period, cost per case also increased rapidly,
3 albeit at a somewhat slower pace.

4 Between '05 and '08, growth in cost per case
5 outpaced that for payments as regulatory changes slowed
6 growth in payment per case to an average of 1.5 percent per
7 year. After Congress delayed the implementation of some of
8 CMS's stringent payment policies, growth in payments per
9 case began to pick up again, and between '08 and '09, per
10 case payments climbed 6.4 percent. Cost per case rose less
11 than 2 percent.

12 Consistent with this pattern of payment and cost
13 growth, margins for LTCHs rose rapidly after the
14 implementation of the PPS, rising from a bit under zero
15 under TEFRA to a peak of 12 percent in 2005. At that point,
16 margins began to fall as growth in payments leveled off.
17 However, in 2009, LTCH margins began to increase again,
18 reaching 5.7 percent.

19 This next slide shows 2005 and 2009 Medicare
20 margins for different LTCH groups as well as the share each
21 presents -- each represents of total providers and total
22 cases. You'll remember that '05 was the peak in LTCH

1 margins.

2 As you can see, there's a wide spread in margins,
3 similar to what you've seen in other settings with a quarter
4 of LTCHs having margins of minus 6.4 percent or less, and
5 another quarter having margins that are 14.1 percent or more
6 in 2009.

7 Margins for for-profit LTCHs are quite a bit
8 higher than those for non-for-profits. We haven't broken
9 out margins by urban and rural area here because there are
10 so few rural LTCHs, about 21 or so. Margins for rural LTCHs
11 are negative, which because of their small size, may
12 reflect, in part, a lack of economies of scale.

13 We looked more closely at high and low-margin
14 LTCHs to get a better idea of what's driving the margins.
15 Because LTCHs often operate in the red when they first open,
16 in this part of the analysis we included only LTCHs that
17 filed cost reports in 2008 and 2009.

18 This slide compares LTCHs in the top quartile of
19 margins with those in the bottom quartile. We found that
20 lower standardized costs, rather than higher payments, drove
21 the differences in financial performance between LTCHs with
22 the highest and lowest margins.

1 High-margin LTCHs also care for more patients with
2 mean total discharges of 533 compared with 410 for low-
3 margin LTCHs. High-margin LTCHs have far fewer high cost
4 outlier cases and lower outlier payments. In addition, they
5 have a lower share of short stay cases, and you'll recall
6 the facility's margins may be negatively affected by both
7 these types of patients. Finally, high-margin LTCHs are
8 much more likely to be for-profit.

9 So for purposes of projecting 2011 margins, we
10 modeled a number of policy changes. First we included
11 updates in 2010 and 2011. For both years, the update was
12 the market basket less adjustments for documentation and
13 coding improvements and the PPACA-mandated reduction for the
14 applicable year. This resulted in a small but positive
15 update in 2010 and an update for 2011 of minus .49 percent.

16 We also made an adjustment for changes to outliers
17 in both years which we estimate will increase aggregate
18 payments. Altogether, these effects will result in somewhat
19 greater growth in provider costs than in aggregate payments.
20 Assuming provider's costs go up at the projected market
21 basket levels, we've projected a margin of 4.8 percent in
22 2011. You'll note that that's a positive margin in spite of

1 the negative update that facilities receive that year.

2 So to sum up our update analysis, the number of
3 facilities and beds are up in 2009. We're seeing stability
4 in the use of services. We've little information about
5 quality in LTCHs, but mortality and readmission rates appear
6 to be stable. LTCHs appear to have access to the capital
7 they need, although the moratorium should now begin to limit
8 opportunities for expansion.

9 Our projected margin for 2011 is 4.8 percent, and
10 our projected decline in the aggregate margin is consistent
11 with expected effects of Congressionally-mandated reductions
12 and updates to payments.

13 We make our recommendation to the Secretary
14 because there's no legislated update to the LTCH PPS. Our
15 draft recommendation reads that the Secretary should
16 eliminate the update to payment rates for long-term care
17 hospitals for rate year 2012.

18 CMS historically has used the market basket as a
19 starting point for establishing updates to LTCH payments.
20 So eliminating the update for 2012 will produce savings
21 relative to a market basket. We do not anticipate any
22 adverse impact on beneficiaries or on providers' willingness

1 and ability to care for patients.

2 Before I turn it over to you, let me fill you in
3 on the findings from our recent panel discussion on quality
4 measurement in LTCHs. As I mentioned, PPACA requires CMS to
5 implement a pay-for-reporting program by October 2013. To
6 help us provide input to CMS on measures that can yield
7 meaningful information about LTCH quality, and hopefully
8 influence the provision of care, staff convened a panel of
9 clinicians, LTCH administrators and medical directors,
10 quality measurement analysts, and researchers with knowledge
11 of best practices in caring for post-ICU patients in LTCHs
12 and other settings.

13 Our panel suggested that CMS begin with a starter
14 set of measures building on those that LTCHs are already
15 using for internal quality measurement purposes. One of the
16 challenges for CMS will be to determine national
17 specifications for the measures, consistent definitions of
18 numerators and denominators, patient inclusion and exclusion
19 criteria.

20 Panelists discussed several outcome measures.
21 These three were considered to be the most basic. Panelists
22 noted that many readmissions to acute care hospitals are

1 planned so that any measure of readmission should focus on
2 unplanned readmissions. However, they cautioned that there
3 are facility characteristics that can affect the rate of
4 unplanned readmissions such as the presence of an ICU in the
5 LTCH. So that will be something that CMS will need to keep
6 in mind.

7 We asked the panel what patient safety issues were
8 prevalent in LTCHs and what measures could be used to track
9 trends in this area and encourage best practices. These
10 measures that I've outlined here are discussed in detail in
11 the paper and I can take any questions you have during our
12 Q&A.

13 I do want to note that the general consensus among
14 our panelists is that most, if not all, LTCHs are already
15 collecting these types of measures internally.

16 Panelists also discussed some process measures
17 that can help to improve quality of life for LTCHs patients.
18 These include a meaningful use of the Electronic Health
19 Record, advanced care planning and end of life discussions,
20 measures that monitor polypharmacy and its affects, and the
21 use of a ventilator weaning protocol.

22 Finally, panelists discussed the issue of risk

1 adjustment of quality measures in LTCHs. There was
2 agreement that risk adjustment was generally not appropriate
3 for patient safety measures as long as present on admission
4 indicator was used. The consensus was that the development
5 of a pressure ulcer was a bad outcome, no matter how complex
6 the patient.

7 Panelists agreed that risk adjustment was
8 necessary for outcomes measures, but the consensus was that
9 risk varies less in LTCHs than in other settings, and many
10 in the group argued that the issue of risk adjustment should
11 not be an impediment to moving forward. There was also
12 general agreement that until a common assessment tool is
13 available, CMS's starter set of measures should be ones that
14 can be collected from administrative data.

15 The findings from our panel meeting are summarized
16 in the paper and will be shared with CMS staff. You may
17 want to discuss whether MedPAC should make a formal
18 recommendation on the development of a pay-for-reporting
19 program for LTCHs. Such a recommendation might include
20 encouragement to move to pay-for-performance as soon as
21 possible.

22 A recommendation could also outline some guiding

1 principles for choosing the starter set of measures, such as
2 that the number of measures should be relatively small,
3 claims-based, and focused on outcomes and patient safety.
4 A MedPAC recommendation could also suggest future directions
5 for quality measurement in the LTCH setting, such as the use
6 of an assessment tool and the types of measures that might
7 be included in an expanded measure set.

8 So now I'll turn back to the draft update
9 recommendation and turn the discussion over to you, and I
10 look forward to your questions.

11 MR. HACKBARTH: Thank you, Dana, well done. So
12 let's see. Which side are we starting on this time for
13 Round 1 clarifying questions? Mitra, that would be you.

14 MS. BEHROOZI: Just being from a state where we
15 don't have LTCHs, is it unique to New York? There are
16 places that don't have LTCHs, right?

17 MS. KELLEY: Yes. New York is, I think, one of
18 the few places that actually does this.

19 MS. BEHROOZI: And do you know anything about the
20 characteristics of the places where it's not du jure but
21 it's defacto that there aren't LTCHs? This might be too big
22 a question for the first round.

1 MS. KELLEY: Much of the growth, for example, has
2 been in the south, in Texas, Louisiana are standard places.
3 And in places where there is not such a strict certificate
4 of need.

5 MS. BEHROOZI: So where you don't find LTCHs where
6 it's not forbidden, where it's not prohibited?

7 MS. KELLEY: What's been very interesting about
8 the growth in LTCHs and the lack of growth in other places
9 is that in recent years, we've seen most of the growth in
10 areas that already have LTCHs. So there appears to be a
11 concentration on duplicating services in particular areas
12 rather than kind of dispersing them.

13 Rural areas typically do not have LTCHs and from a
14 policy perspective, one would suspect that that's because
15 the population simply doesn't support that many critical
16 care patients in the area. Other than that, I don't have --

17 MS. BEHROOZI: Do you have a sense of where the
18 services are provided? I mean, can you --

19 MS. KELLEY: When they're not in an LTCH?

20 MS. BEHROOZI: Yeah.

21 MS. KELLEY: Sure. Generally, patients are -- not
22 all, but many patients stay in the acute care hospital for

1 longer and then they generally go to other types of post-
2 acute care providers, particularly SNFs after the longer
3 hospital stay.

4 MR. HACKBARTH: Mitra's questions make me think it
5 might be useful for the new Commissioners to just spend
6 another minute on sort of the context for this particular
7 discussion. One feature of it Mitra has put her finger on
8 which is the distribution patterns of LTCHs is interesting
9 at least. They are concentrated in, as Dana just pointed
10 out, rather than spreading. A lot of the new development is
11 in areas where there are already LTCHs. So there are large
12 swaths of the country dealing with, presumably, very similar
13 sort of patients but doing it in other types of settings.

14 Related to that, of course, is that LTCHs are a
15 relatively expensive setting. And so, four years ago, was
16 it, Dana, the Commission recommended that in order to make
17 sure that this very expensive resource was used for the
18 patients who could best benefit from the level of care and
19 cost of care, there ought to be facility and patient
20 criteria on who's eligible for a Medicare payment.

21 Congress asked CMS to do a report on that, which
22 is, as Dana said, is still pending. Could you put up Slide

1 10 for a second, Dana? Another interesting facet of the
2 history here, and Nancy has often remarked on this. So here
3 we have the advent of a prospective payment system. Usually
4 the idea for doing prospective payment is it's going to help
5 make the system more efficient and lower cost.

6 Well, we did prospective payment and cost growth
7 and revenue growth took off. It became an attractive
8 business opportunity for some people and we had rapid growth
9 in the number of LTCHs, but again with this peculiar pattern
10 of only in some parts of the country, which is, in part, a
11 function of regulatory restrictions, but not entirely, and
12 then sort of piling on in select markets, all of which led
13 us to be concerned, again, about whether we have a sensible
14 payment system, whether the criteria of who's going in are
15 proper, and also concern about the payment levels.

16 Some of these issues have been dealt with by CMS
17 and the Congress through ways that, at least to me, are
18 cruder than I would like. The restrictions on the referral
19 patterns that CMS instituted by regulation, four or five
20 years ago, to me is a cruder approach than facility and
21 patient criteria.

22 And then most recently, Congress has come in with

1 an absolute moratorium, which is sort of the ultimate crude
2 tool. But there's some really unique dynamics at work in
3 this field. I just wanted to highlight some of that history
4 for the new Commissioners.

5 Okay. Continuing with Round 1 clarifying
6 questions, Tom?

7 DR. DEAN: Yeah, just to follow up on Mitra's
8 question, I suspect it's beyond any information you have,
9 but this is a sort of unique model of care and it would seem
10 -- are you aware of any comparative studies?

11 I mean, we know these patients get taken care of
12 in places where these facilities don't exist, obviously, and
13 through other means. It would seem that there would be a
14 real value in trying to track patients that have roughly
15 equivalent problems through different routes of care and see
16 if we can come to some indication about both cost and
17 outcome.

18 MS. KELLEY: The Commission took a look at that
19 back -- we reported on it in 2004. We used 2001 data. So
20 it's dated. But we looked at areas without -- what we tried
21 to do was look at patients who looked similar to LTCH
22 patients, but who did not use LTCHs, and to see how their

1 episode costs compared to LTCH patients.

2 The problem in our analysis and that has affected
3 subsequent research also, is that we don't have any outcome
4 data or quality measures. So we have no way to decide
5 whether maybe it does cost more in an LTCH, but they may be
6 getting much better care or much more appropriate care
7 having better outcomes.

8 What we found and what other researchers have
9 found as well is that the episode costs for LTCH patients
10 are generally higher, and in some cases much higher, than if
11 patients don't use LTCHs. But that cost difference really
12 narrows if you focus on the most complex patients with the
13 highest severity levels and, I think, declines to sort of
14 statistical insignificance. That's also especially true for
15 ventilator-dependent patients who are cared for in LTCHs.

16 DR. DEAN: Do you know what proportion of the
17 patients admitted to LTCHs meet those criteria, the most
18 complex?

19 MS. KELLEY: I can dance around that one a little
20 bit. About 12 percent of patients have been -- in
21 aggregate, have been on a ventilator for more than 96 hours.
22 That percentage differs across different facilities. One of

1 the national associations did a study recently looking at --
2 trying to look at the cost of LTCH care, and they found that
3 LTCH care was a savings for about, I want to say, 40 percent
4 of patients. Those again were the sickest patients.

5 So there do seem to be, shall we say, a
6 substantial number of patients that probably are not of the
7 highest acuity.

8 MR. HACKBARTH: Round 1 clarifying questions.
9 George?

10 MR. GEORGE MILLER: The staff has done an
11 excellent job of providing demographic information in most
12 of the other presentations to date, but I didn't see --

13 MS. KELLEY: I'm sorry about that. I can speak to
14 that.

15 MR. GEORGE MILLER: Okay.

16 MS. KELLEY: And also, we'll make sure that that's
17 included in the chapter as well.

18 MR. GEORGE MILLER: Yes.

19 MS. KELLEY: The use of the services is pretty
20 much in line with demographics, with the general
21 demographics of the program. Slightly more minority use,
22 but not -- I wouldn't say an alarming difference. What is

1 very interesting is that other researchers who have looked
2 at the use of LTCH care following discharge from an ICU with
3 ventilator dependency, they have found a fairly significant
4 difference in LTCH use among African-American patients, and
5 the research that I've seen has not been able to tease out
6 whether that's a referral issue, whether that's a family
7 preference.

8 The mortality rate for patients who are
9 ventilator-dependent, when they leave the acute care
10 hospital, is very, very high. And so, there are patients
11 who go to hospice and there are differences in patient
12 election of those services across demographic groups. I
13 will definitely refer to this in the paper.

14 MR. GEORGE MILLER: And a follow up to that, 70
15 percent of this is paid by Medicare. Do you know what the
16 breakdown of the rest of the 30 percent would be?

17 MS. KELLEY: Off the top of my head, I'm going to
18 get it wrong, so I will also include that.

19 MR. GEORGE MILLER: Okay. Do you know if Medicaid
20 is a large --

21 MS. KELLEY: Medicaid is not large there.

22 MR. GEORGE MILLER: So this is not a dual eligible

1 issue as well, or would it be?

2 MS. KELLEY: I'm not sure.

3 MR. GEORGE MILLER: Okay. Thank you.

4 DR. BERENSON: I missed any discussion on what the
5 cost-sharing obligations of beneficiaries.

6 MS. KELLEY: Well, this is the hospital service.
7 You know, generally, an acute hospital service. So it's the
8 same premium and cost-sharing as in the acute care hospital
9 and as with as Cristina was talking about, with IRFs, if the
10 patient comes directly from the hospital they've already met
11 that obligation.

12 DR. BERENSON: With Bruce's notion of the 30-day
13 episode.

14 MS. KELLEY: Yes.

15 DR. BERENSON: So, theoretically, but these are
16 very sick patients, or many are. Okay.

17 MS. KELLEY: These are. I would say in most cases
18 home health care is probably not the substitute if that's
19 the question.

20 DR. BERENSON: Yeah, and so that's where I was
21 going next. In the work you did five or six years ago,
22 whenever it was, the alternatives where you don't have LTCH

1 presumably would be either a continued long stay in an acute
2 care hospital or in some cases the SNF --

3 MS. KELLEY: Yes.

4 DR. BERENSON: -- the complex SNF patients.

5 MS. KELLEY: Yeah. Some areas do have very high
6 complexity SNFs where patients are cared for.

7 DR. BERENSON: And there, we would then have a
8 very significant incompatibility of cost-sharing obligations
9 between the patient, the beneficiary who's in a SNF and
10 after day 20 is facing a daily significant out-of-pocket,
11 whereas here they're not.

12 MS. KELLEY: True.

13 DR. BERENSON: Okay.

14 MR. KUHN: Two quick questions: One on page 18,
15 when you were talking about the suggested outcome measures,
16 and I was particularly interested in the one in the in-
17 facility mortality. I remember looking at some data several
18 years ago where it appears that mortality rates for short-
19 stay patients was much higher than for longer-stay. One of
20 the policy assumptions people were drawing from that is that
21 these individuals perhaps maybe should have been more
22 directed to hospice rather than admission to a LTCH.

1 When you had this conversation with the community,
2 is there a discussion of differentiating on the inpatient
3 mortality in terms of short stay, long stay?

4 MS. KELLEY: One of the things we heard loudly and
5 clearly from our panelists was that often patients end up in
6 the LTCH because physicians in the acute care hospital want
7 to shift a patient elsewhere, and either the family or the
8 physician wants to avoid difficult decisions. There was a
9 consensus that patients come to the LTCH sometimes who
10 should not come. Their survival, expectations for survival
11 are quite low, and it's probably not the most appropriate
12 place for them to be cared for. On the other hand,
13 sometimes there aren't easy decisions about where else they
14 should go.

15 MR. KUHN: Thank you. And in that regard,
16 obviously, a facility or patient criteria would probably
17 help in some of the decision-making as we go in that
18 direction. So I know CMS has a report pending, but I also
19 understand the industry has put together some pretty
20 thoughtful recommendations of some criteria. Have we all
21 reviewed their recommendations, and do we have a pretty
22 favorable view of those, or what's the --

1 MS. KELLEY: I think the criteria that the
2 industry has developed, or has recommended, is similar to
3 the types of criteria that the Commission recommended back
4 in 2004 -- setting up parameters for staffing
5 qualifications, and also sort of some patient criteria that
6 can help sort of narrow the patient population a little bit.
7 RTI did the work for CMS on criteria, and they had very
8 similar recommendations as well.

9 DR. MARK MILLER: This may be dated, but at the
10 time that the two associations developed their criteria
11 there was some difference between the two of them.

12 MS. KELLEY: Yes.

13 DR. MARK MILLER: Is that still true?

14 MS. KELLEY: The industry, I think, has been
15 working together, increasingly working together on coming to
16 consensus on these issues, but I think that there is sort of
17 a general waiting to see what CMS is going to say.

18 DR. MARK MILLER: Yeah, and I just tease this out
19 because I think perhaps behind your question is if the
20 industry has criteria and we've suggested criteria, and I
21 think there is some static between the two --

22 MS. KELLEY: There was --

1 DR. MARK MILLER: -- associations for a while,
2 which may be working its way out. And then there's this
3 issue of where the circumstance stands with CMS.

4 And I just want to make this conceptual point just
5 to make sure. When we talk about the criteria here, we're
6 talking about the criteria for this level of care --

7 MS. KELLEY: Right.

8 DR. MARK MILLER: -- as opposed to this is what it
9 takes to get into an LTCH. I mean, as Bob is pointing out,
10 a person like this can be treated in other settings. So
11 when we spoke to the criteria, what we meant was a level of
12 care that's needed as opposed to you have to go to an LTCH
13 when you meet these criteria.

14 MR. HACKBARTH: I would think that the moratorium
15 is a reason for the associations to sort of get together and
16 say --

17 MS. KELLEY: Well, there's -- I would say that
18 there are disagreements in the industry about the pros and
19 cons of the moratorium.

20 MR. HACKBARTH: So my recollection, Dana is that,
21 and this is going to be a gross oversimplification, but
22 there's sort of a group of LTCHs that have been around for a

1 long time --

2 MS. KELLEY: Yes, that's right.

3 MR. HACKBARTH: -- that are largely or exclusively
4 not for profit.

5 MS. KELLEY: That's correct.

6 MR. HACKBARTH: And then there are the newer ones.

7 MS. KELLEY: Yes.

8 MR. HACKBARTH: Are the associations divided along
9 those lines?

10 MS. KELLEY: Not perfectly, but yeah.

11 MR. HACKBARTH: Okay. Nancy.

12 DR. KANE: Yeah, a couple questions. One is
13 something just to link up something I've been working on.
14 Are the staff required to get vaccinated for the flu season?

15 MS. KELLEY: The staff have to meet all the
16 qualifications that acute care hospitals have to meet. So
17 if the answer there is yes --

18 DR. KANE: That they don't have to.

19 MS. KELLEY: -- then they don't here either.

20 DR. KANE: Because I was reading that CDC was
21 pointing out that they really should, but in long-term care
22 facilities there's a much lower staff influenza vaccination

1 rate, and I just wondered if that would be one of the
2 criteria we'd want to put in there since these people seem a
3 pretty vulnerable to --

4 MS. KELLEY: These people are very vulnerable,
5 yes.

6 DR. KANE: Then on slide 13, on the differences
7 between the high margin and low margin I'm wondering two
8 things. One is do we know if there are any quality
9 differences even in mortality and discharge?

10 MS. KELLEY: Not really significant ones.

11 DR. KANE: So they look the same.

12 And do we know for the high-margin ones whether
13 there' are any physician ownership issues around who goes,
14 whether there's physician ownership of the high-margin ones
15 that's any different than the low-margin ones?

16 MS. KELLEY: I don't know the answer to that.

17 DR. KANE: Because I think we're starting to
18 collect that data. I thought we were. I'm not sure if
19 that's actually happening. I'm wondering if it might be
20 useful to get a sense of whether there is some selection
21 going on in that referral that has to do with physician
22 ownership issues.

1 MS. KELLEY: Okay.

2 MR. HACKBARTH: Clarifying questions? Kate.

3 DR. BAICKER: Just a quick one, I was very excited
4 about all the different outcome measures you were talking
5 about. To what extent are those measurable in other
6 populations, so that we could get a better answer to the
7 comparability of treatment in different settings? Do we
8 have the data we would need to compare different settings?

9 MS. KELLEY: CMS has been working on a
10 demonstration of the post-acute care tool that they tested
11 in a variety of post-acute care settings including LTCHs,
12 and the report on that demonstration is due in June or --
13 June? July?

14 June. So we're very much looking forward to the
15 results of that, and CMS's goal has been to try to develop a
16 tool that can be used across the post-acute care settings.

17 What we won't have is a similar kind of tool in
18 the acute care hospital, and of course that's a place of
19 overlap here too. But you know it certainly moves us in the
20 right direction, and it would provide a lot of information
21 about the care that's provided inside LTCHs, much more than
22 we currently have.

1 MR. HACKBARTH: Round one questions?

2 [No response.]

3 MR. HACKBARTH: Round two comments, reactions to
4 the recommendations? Mitra.

5 MS. BEHROOZI: I would support the recommendation,
6 and certainly the concerns about quality are well placed.
7 But just the concerns about having a payment system that
8 seems to incent, I don't know whether it's building
9 facilities or selection of patients or whatever, that we
10 just seem to be paying too much for.

11 You said it, Dana. I'll just repeat it. The
12 industry's own study showed that there was an efficiency
13 gain or whatever, a savings, in a minority of the cases that
14 we're paying them too much for is of real concern. So with
15 that, I support the recommendation.

16 DR. DEAN: Yeah, I'd support the recommendation.
17 I would also support Mitra's comments. It seems to me that
18 sitting here with a kind of unique model of care for which
19 we have a moratorium on is not a very satisfactory
20 arrangement. I mean if this is a good way to do things, we
21 should take off the moratorium; if it's not a good way to do
22 things, then we should get much more aggressive in the other

1 direction.

2 So the quality issues I think are crucial, and the
3 comparative, some sort of comparative information about how
4 this approach relates to the other alternatives and whether
5 or not the patients that are entering these facilities
6 really are the ones that stand to benefit from this type of
7 care are questions we don't really have answers to, it
8 doesn't sound like right now. And I think we really need
9 answers if we're going to come up with a logical approach.

10 MS. KELLEY: I think I have just one response to
11 that. I think this was suggested in one of the earlier
12 presentations today. I think in home health. I think we've
13 got a lot of good actors here and then perhaps other
14 providers who are not performing the way we would like. So
15 I think the challenge is to try and direct the care in the
16 way that we want as opposed to in a way that sort of is a
17 financial performance issue.

18 DR. DEAN: Sorting out the good guys from the bad
19 guys has always been a challenge.

20 DR. NAYLOR: I also support the recommendation and
21 strongly endorse Tom's recommendation about comparative
22 effectiveness work. I don't know that we do that, but

1 studies that would help us to uncover how similar
2 populations are being served, how well and what are the
3 costs associated with it. It's a great opportunity, and I
4 think we need to encourage it.

5 MR. HACKBARTH: One of the reasons that this
6 demonstration project and developing common information
7 tools across the different post-acute settings is so
8 important, that's the raw material with which you can begin
9 to look at oh, these patients require this resource and
10 other patients can be cared equally well for in another
11 setting. So we're making progress towards that.

12 Peter.

13 MR. BUTLER: I support the recommendation and
14 would like a short editorial as I reflect over our decisions
15 over the last day and a half. We have again supported the
16 migration of post-acute care to free-standing for-profit
17 entities in a fairly rapid way and pretty much locked in, in
18 many cases, double-digit profit levels.

19 This is nothing against for-profits. I think they
20 manage costs well. They often add discipline to the market.
21 So that's not the point. But we have kind of -- that's what
22 we've in effect done, embraced that.

1 My second point, so what are the implications? It
2 runs maybe, or maybe not, counter to the bundling that we
3 need to get on with. At least it is posing either greater
4 barriers or greater facilitations, and I think we need to
5 worry about that.

6 Secondly, we really never talk about the
7 willingness of the for-profits in the post-acute world to
8 accept the charity care. We are just focusing on the
9 Medicare access. So I'm a little concerned for those post-
10 acute care providers that are in the non-Medicare business,
11 the potential implications.

12 Finally, I think that we do need to think about
13 again for-profits aren't bad, but who really do we want to
14 be the assemblers of the bundles. We know the MA plan
15 should do it. I think we need -- I'm not sure hospital-
16 centric bundling is any better, and I'm not sure that
17 multispecialty physician group bundling is necessarily
18 better. We need patient-centric bundling, and I don't know
19 how we have that discussion so that you really kind of --
20 otherwise, everybody is trying to be the bundler, and we're
21 kind of letting it happen in ways potentially that I think
22 we could be a more proactive voice in thinking about how

1 this happens.

2 MR. HACKBARTH: Peter, when you say your first
3 point, when you say that the recommendations we've discussed
4 encourage the growth of a for-profit, free-standing, post-
5 acute industry, I take it what you mean by that is because
6 the hospital-based services in the post-acute area typically
7 have much lower or negative margins and we're not making any
8 payment adjustment for that, which is causing them to exit,
9 these hospitals to exit these businesses in favor of it
10 being taken up by free-standing, for-profit providers. Am I
11 understanding you correctly?

12 MR. BUTLER: A little bit of that, but I'm not
13 trying to protect underperformance in the hospital-based
14 services. I'm really not.

15 I just think that the other way of looking at it
16 is the profit margins that we are supporting are encouraging
17 the for-profits to enter and do more of it, maybe even more
18 than is necessary. So set aside any biases against the
19 hospital-based because actually in many of these areas we
20 aren't that great at doing it. It's not our primary focus.

21 MR. HACKBARTH: Generally speaking, the conclusion
22 that you draw from that is we need to be aggressive in

1 holding down the rates and squeezing out the very high
2 profit margins that are attracting.

3 MR. BUTLER: [Off microphone.] Yes.

4 DR. CHERNEW: I support the recommendation, and I
5 very much support what Peter said although I want to point
6 out one thing. The problem is if you think there's
7 heterogeneity, which we often think there is, you can't
8 squeeze out the profit margins of the for-profits without
9 destroying the profit margins of the ones that you might.
10 I'm not arguing this because of the quality measure issue,
11 but you can't get rid of the ones that you think are for-
12 profit and the ones that you have that implication for
13 without hurting the other ones even more because we don't
14 have that lever.

15 And the problem that I think we have is a review
16 of some personal bias. I am skeptical that we -- and we, I
17 mean that sort of very broadly -- are nimble enough to both
18 observe everything we would want to observe in terms of the
19 heterogeneity and then develop the regulations in a way to
20 get it done much more precisely. So in the end I support
21 Peter's view of having a much more holistic, bundled view.

22 We talked about like 10 different types of payment

1 mechanisms. Roughly, five or six of them are all long-term
2 care type, post-acute type services with some level of
3 substitutability.

4 We have very siloed discussions, very inconsistent
5 incentives in terms of co-pays, as Bob pointed out about
6 what happens, very different incentives about profit
7 margins, very different incentives about a whole series of
8 things, very little ability to have quality measures. We
9 often treat the quality measures completely different, so
10 the same person in a nursing home might have a different
11 quality set of metrics than that person in a long-term care
12 facility.

13 So my view is although I completely agree with
14 Mary that we need much more clinical research I don't view
15 that as fundamentally informing payment strategy as much as
16 actually clinical providers, to help them decide what to do.
17 And we need to make sure that we have the payment system
18 that enables the providers that want to do well and succeed,
19 with that information, to be able to succeed instead of one
20 that just pushes care down.

21 And we need to come up with quality measures that
22 are patient-centric across the whole type of patient as

1 opposed to site of care, place-centric. I guess site and
2 place are redundant, but anyway centric.

3 I think my general spirit of the recommendations
4 would be to move as quickly as we can. I like this
5 recommendation.

6 But separately, sort of our other June report type
7 thing, to try and get through these silos instead of
8 spending all of our time trying to look within the silos
9 about huge amounts of heterogeneity, and then we realize
10 yeah, but those people could be here, and then we have to do
11 another one, and then we have to do another one.

12 Then we want to put something in, but someone
13 points out there is some sort of cleavage in the payment
14 system. So you get this if you've been discharged from this
15 after three days, but not after four days.

16 So you see all these ones with green and red bars,
17 and you see people, like I think it was Evans. They split
18 out. They were all lumped in the middle. Now they're all
19 lumped to the sides.

20 And we have an exception for the 25 percent rule,
21 but if it's even, if it's a county that begins with a vowel,
22 we give them an exception. And you know all --

1 MR. HACKBARTH: Payment reform is important, I
2 take it.

3 [Laughter.]

4 DR. CHERNEW: Right. So I guess my point is I
5 think we should just go forward with this and devote a lot
6 of these other more detailed energies towards getting us to
7 where we want to go as opposed to the interim steps in this
8 bad system.

9 MR. HACKBARTH: Yeah. Cori.

10 MS. UCCELLO: I agree with the recommendation, and
11 I agree that we do need to think about this stuff more
12 holistically and substitution and make sure all that makes
13 sense, but that's not for today.

14 MR. GEORGE MILLER: I agree with the
15 recommendation. I agree with Peter except for I'd like to
16 substitute the word "bad actors" -- I think Nancy used that
17 term -- versus "for-profit," which is probably surprising
18 coming from me.

19 And I also agree with Michael that we should
20 probably try to find a way to find quality measures that go
21 across silos and sectors, so that we can evaluate
22 collectively should a patient be in an LTCH versus an acute

1 care hospital setting and be able to differentiate that.

2 Like it or not, there is still a cost issue. Is
3 the quality better, but do we pay \$1,000 more for it in a
4 different setting? So those are some of the issues we
5 should discuss.

6 And certainly quality has got to be the lever
7 first, I think, and certainly cost, but we do it inversely.
8 We talk about the quality, but we look at the revenue data,
9 and then we make the decision. So somehow we got to link
10 those two stronger together in my view.

11 DR. BERENSON: I support the recommendation and at
12 this moment have nothing to add to what has been a very good
13 conversation.

14 MR. KUHN: I'm generally supportive of the
15 recommendation although I would be a lot more enthusiastic
16 if we could add to the recommendation a restatement of I
17 guess the four-year ago proposal of some classification
18 criteria that's out there.

19 You know, by the time this report is published in
20 March of next year we'll be two years out from when a report
21 is due from CMS. The industry has already coalesced around
22 a set of criteria, and if you look at this industry, the

1 only -- as it was reported here, the only criteria for LTCHs
2 is that it's an acute care hospital with an average length
3 of stay of 25 days or more. You know.

4 I think they're entitled to a little bit more or
5 else they're going to be caught in this quagmire that we're
6 caught in here -- is that it's hard to make decisions when
7 you really don't have these things nailed down a little
8 tighter. And I think if we could rethink that and put
9 something, a little stronger statement there, I think that
10 would be very helpful.

11 MR. HACKBARTH: Well, what we could do is rerun
12 that recommendation in a text box and include a passage in
13 the text, reiterating how important we think this is and
14 urging to get on with it.

15 Nancy.

16 DR. KANE: Yeah, I support the recommendation. I
17 think we don't know enough to not accept that the profit
18 margins seem and the supplies seem -- they're there, and we
19 don't know if we want more or less of it at this point.

20 I just wanted to follow up on something Bob
21 mentioned about the cost-sharing difference between a SNF
22 and a LTCH. That's kind of worrisome to me, and I'm

1 wondering how many people actually go out to the SNF 20
2 days, whatever it is, and then switch to the LTCH to avoid.
3 I wonder how much of this is being driven by the cost-
4 sharing aspects of demand rather than the medical needs as
5 well, and it would be interesting to sort of get a sense.

6 I don't know if any of these people get admitted
7 from SNFs, but if they are it would be interesting to see
8 what that episode looks like and whether it's right at the
9 day they start cost-sharing that they get transferred into
10 the LTCH.

11 MS. KELLEY: It's something close to 20, 18 to 20
12 percent --

13 DR. KANE: That's a lot.

14 MS. KELLEY: -- that get admitted, well, not
15 necessarily directly from a SNF. They get admitted -- they
16 are not admitted directly from the acute care hospital.
17 Most of these patients were somewhere. I mean most of these
18 patients weren't at home.

19 DR. KANE: If you're on a ventilator, you weren't
20 at home. So it would be nice get a better sense.

21 And maybe one recommendation we could add to all
22 this is something about the co-pay differential and how that

1 incentive to go to an LTCH when the co-pay starts picking up
2 in a SNF might be waived if indeed that's what's happening.
3 I don't know.

4 MR. HACKBARTH: You know, I agree with the general
5 point about looking at the co-pay structure around issues of
6 substitution of services. That's really important.

7 But we also need to remember that the way this
8 system works now the vast majority of patients have
9 supplemental coverage. That means these issues are
10 irrelevant. They're not facing cost-sharing at the point of
11 service. So the issues are less sharp than they seem in the
12 abstract.

13 Bruce.

14 DR. STUART: I support the recommendation.

15 DR. BAICKER: I support the recommendation. I
16 support Mike's little rant. And I'm wildly --

17 [Laughter.]

18 DR. CHERNEW: [Off microphone.] [Inaudible].

19 DR. BAICKER: And I'm very enthusiastic about
20 increased data availability and better metrics that would
21 let us look across silos better.

22 DR. CASTELLANOS: I likewise support the

1 recommendation. I think the discussion has been very, very
2 positive, and I look forward to trying to solve this post-
3 acute care setting dilemma.

4 MS. HANSEN: I support the recommendation, and I
5 think I picked up also this whole issue of general cost-
6 sharing as a larger topic. I know definitely that right now
7 there's a great deal of coverage by supplemental policies,
8 but that is going to be changing as a result of PPACA.

9 So I just wonder if when we talk about benefit
10 design in the future and we were talking about cost-sharing,
11 especially with the home health benefit, whether or not
12 there's work underway or whether there is some work that we
13 could think about that speaks to the whole Medicare sets of
14 programs that we do and is existing cost structure of what
15 the co-pay would be, with the asterisk, knowing that right
16 now these supplemental programs do cover it. But if we're
17 starting to move to the principal of cost-sharing, could we
18 have something that's a little bit more unified, describing
19 this, and having it come described by virtue of the current
20 siloed programs?

21 But I think it was Mike who was starting to say,
22 you know, it's really regardless of let's just say that

1 there's an example of a septicemia or some of the diagnoses
2 that are listed here in these areas. What would normally,
3 possibly happen from a more client basis -- occur -- because
4 if you were in a rural place where you don't have this
5 versus a place that could use other services than a
6 facility-based service? How does that show up in the cost-
7 sharing and trajectory that they would go through?

8 So it's turning it around, but anticipating what
9 we need to think about the whole concept of appropriate
10 cost-sharing in the benefit design for the future.

11 MR. HACKBARTH: On Jennie's first point, PPACA, my
12 recollection -- somebody correct me if I've got this wrong -
13 - is that by 2015 the insurance commissioners are supposed
14 to submit recommendations on including cost-sharing in the 2
15 most popular models of supplemental coverage, which
16 currently have basically no cost-sharing at the point of
17 service. Is that right?

18 Scott.

19 MR. ARMSTRONG: I, too, support the direction that
20 the recommendations are taking us in.

21 I also just want to say I really appreciate how
22 Peter and Mike framed the broader set of issues that I look

1 forward to us talking about.

2 I was just looking and recognized if you put
3 skilled nursing, the inpatient rehab and long-term acute
4 care hospitals, what we spend on those, it's starting to get
5 to get to \$40 billion. At this inflation rate, it will
6 catch up with what we spend on provider payments pretty
7 soon. So it just seems to me that the way to get it under
8 control and to feel that we're getting a better return is to
9 look at how it all holds together in some different way from
10 the way in which this siloed approach requires us to look at
11 it.

12 DR. BORMAN: I support the recommendation. I
13 would just throw out the thought that as we identify some
14 areas about, that potentially could be enlightened by
15 comparative effectiveness reviews or sponsorship of work,
16 perhaps we should be having a running list that we might
17 share as PCORI takes shape and moves forward because some of
18 the things that were kind of in an abstract on the starter
19 set for them to look at may or may not be at the point of
20 the sword so much as some of the things that we might help
21 identify in our conversations.

22 MR. HACKBARTH: Okay, I just want to offer a

1 thought on this issue of for-profit, not-for-profit. You
2 know we've got 17 commissioners. I imagine we probably have
3 17 different points of view on that issue.

4 My own I think may be similar to Peter's. I don't
5 personally have an objection in principle to for-profit
6 institutions. I don't think for-profit are inherently worse
7 than not-for-profit.

8 I do believe though that they respond differently
9 to the payment systems, and we see that in a variety of
10 different ways. One way, which Nancy flagged, is if you
11 have really substantial overpayments that's going to attract
12 a lot of for-profit activity, aggressive entry into places
13 where there are high profit levels.

14 Another way we see evidence of in the hospital
15 payment system, if you remember the low pressure, medium
16 pressure, high pressure analysis that we discussed
17 yesterday. For-profits, even when they were under low
18 pressure, tended to have lower costs whereas not-for-
19 profits, if they have high revenues, are inclined to say:
20 Oh, I have a mission. You know. It's to delivery health
21 care to my community. I've got more money. I'm going to
22 invest more in that mission.

1 A for-profit is going to look at oh, I need to
2 make a return to my shareholders, and I'm not going to maybe
3 incur some additional costs that a not-for-profit might. So
4 they, for sure, respond differently to the incentives and
5 typically will respond aggressively.

6 I think the job of the Commission and what we need
7 to do on Medicare is make sure that our payment systems are
8 fair and don't allow undue opportunities for people to make
9 inappropriate profit, and we need to maintain pressure
10 across all of the payment systems.

11 Then I join Mike's --

12 DR. CHERNEW: [Off microphone.] Rant.

13 MR. HACKBARTH: -- rant.

14 [Laughter.]

15 MR. HACKBARTH: You know, about the urgency and
16 the importance of moving on and getting to new payment
17 models and getting out of the fee-for-service silos that
18 we're in. So that's my final word for this meeting.

19 Thank you, Dana.

20 We'll now have our public comment period.

21 MR. KALMAN: Good morning. I'm Ed Kalman. I'm
22 general counsel to the National Association of Long-Term

1 Care Hospitals. I'd like to help clarify the Medicaid
2 question that was raised.

3 As you see, the growth in long-term care hospitals
4 in the states of Texas and Louisiana, those states have a
5 limit on Medicaid days. They only allow 30 Medicaid days.
6 So these patients with very long stays have used these days
7 up. If you look at the data, a lot of these patients are
8 dually eligible. I come from Massachusetts. We have -- and
9 New York where New York Health and Hospitals in the long-
10 term care hospital business, we have lots of Medicaid
11 patients because they cross over. So that's helpful to that
12 question.

13 We are also the association that did the study on
14 cost-effectiveness, and we did it because we wanted to show
15 over a hospital episode of care whether there are patients
16 where the Medicare program saves money. And we wanted to
17 come up with a predictive model so that those patients could
18 be identified before they came to a long-term care hospital
19 with administrative data that's available to both the
20 hospitals and later to CMS so they can do a payment
21 adjustment.

22 So we are recommending a payment model that

1 rewards long-term hospitals for admitting cases that save
2 money, and it's quite substantial. We found -- we've got a
3 linked file; we followed the cases -- that long-term care
4 hospitals in 2010, using 2010 payment policies, saved the
5 government \$282 million. You take that and what CBO would
6 do with that over five and ten years, it's not short money.

7 Also, we've identified these are high CMI cases,
8 as you know, that are at very high risk of readmission if
9 they stay in acute hospitals because of the incentives of
10 IPPS which also generates more costs.

11 So I hope that's helpful.

12 MR. HACKBARTH: Okay. We are adjourned. Thank
13 you.

14 [Whereupon, at 11:53 a.m., the meeting was
15 adjourned.]

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