

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

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

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

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

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

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

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

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

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

1 me turn it over to you.

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

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

14 The presence of the sequester will affect the
15 savings estimates for the Commission's recommendations. In
16 the first example here, a sector has a base rate of \$100 in
17 2013 and a statutory update of 1 percent. In 2014, payments
18 increase by \$1 for the update and decrease by \$2 for the
19 sequester to \$99. If the Commission recommends a 1-percent
20 update for 2014, this would result in a payment amount of
21 \$101, and compared with the sequester baseline, the
22 Commission's recommendation would have a cost.

1 The second example shows a sector with a base rate
2 of \$100 and a statutory update of 1 percent, and, again, for
3 2014 the sequestered amount is \$99. But for this sector,
4 the Commission's recommendation is a negative 2-percent
5 update, resulting in a payment rate of \$98. And when
6 compared with the sequester baseline, the Commission's
7 recommendation would result in savings.

8 I'll just stop there.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 distribution of payments across different categories of
2 hospitals.

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

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

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

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

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

1 remained steady at approximately \$26 billion in 2011 and in
2 2012, and interest rates on debt are at historically low
3 levels.

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

10 As you can see in red on the slide above, the
11 cumulative change in inpatient discharge volume from 2004 to
12 2011 was approximately negative 8 percent per beneficiary,
13 or about negative 1 percent per year. By contrast, the
14 green line displays a cumulative change in outpatient
15 services of approximately 34 percent per beneficiary over
16 the same time period, and this equates to nearly a 5-percent
17 increase per year.

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

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

1 decline in medical inpatient discharges.

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

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

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

1 Hospitals received \$1.5 billion more from services that they
2 would have under physician office rates in 2011, and this
3 amount increased by approximately \$200 million from 2010 to
4 2011. Therefore, if this shift in site of service
5 continues, we expect Medicare payments will increase
6 further.

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

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

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

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

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

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

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

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

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

14 Now, after data became available on 2008 and 2009
15 documentation and coding, CMS reduced payments in 2011 and
16 2012 to offset the remaining effects of documentation and
17 coding that occurred in 2008 and 2009. But no changes in
18 rates have taken place to offset changes in documentation
19 and coding that occurred in 2010. An additional adjustment
20 is needed to stop further overpayments and recover past
21 overpayments that have or will occur in 2010 through 2013.

22 Moving on, in this next chart we compare increases

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

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

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

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

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

8 In 2011, the overall Medicare margin was minus 5.8
9 percent, roughly one percentage point lower than in 2010.
10 The decrease in the overall Medicare margin from 2010 was
11 primarily due to a drop in the inpatient margin, which fell
12 to minus 4 percent. The decline in the overall margin in
13 2011 would have been lower if it were not for several
14 temporary payment adjustments that were in place in 2011 and
15 2012.

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

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

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

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

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

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

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

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

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

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

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

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

12 The point of this slide is to show that after all-
13 payer margins fell in 2008 -- we note that Craig said that
14 hospital costs tended to go up at a slower rate. However,
15 the graphic also shows that all-payer margins rebounded from
16 2008 back to close to historic highs in 2010 and 2011. So
17 given that their all-payer financial performance is strong
18 in recent years, one possibility is that this rebound in
19 financial performance may result in higher cost growth in
20 2013. However, it's also possible that hospitals will
21 continue to restrain their cost growth due to limits on
22 Medicare updates, declining Medicaid payment rates in some

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

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

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

1 And that brings us to what we call our relatively
2 efficient hospitals. To determine who is efficient, we use
3 the same criteria as the last couple years. I will not go
4 into them in detail, but hospitals are categorized as
5 relatively efficient if they perform relatively well on a
6 mix of mortality, readmissions, and standardized inpatient
7 cost per case in three straight years -- 2008, 2009, and
8 2010. After identifying who historically has done well, we
9 then look at how well they performed in 2011.

10 Here are the results. We ended up with a group of
11 297 hospitals that have historically been relatively
12 efficient providers for three straight years prior to 2011.
13 This group of 297 hospitals represents about 14 percent of
14 all IPPS hospitals that have usable data over all four
15 years.

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

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

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

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

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

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

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

15 The bottom line from this chart is that the net
16 effect of this change in Medicare payment policy is expected
17 to be small for the industry on average; in other words, the
18 2014 payments in the two green boxes will be roughly equal
19 to the \$11 billion in DSH payments that they received in
20 2011. The payments will be redistributed amongst hospitals,
21 but the aggregate level of payments will be similar.
22 However, it is important to note that in future years, if

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

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

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

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

14 Now just to review the update rationale.

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

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

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

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

9 First, we see strong outpatient volume growth.

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

14 Now I'll open it up for discussion.

15 MR. HACKBARTH: Okay. Thank you all.

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

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

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

4 The first one, Slide 13. So you make reference
5 here to the HIT payments and you also address them in the
6 chapter and you suggest that they are about \$2.5 billion
7 this year and \$3 billion next year, and these are one-time
8 payments. So the question, just to get more specific, on a
9 114 million or whatever it is base, what would the run rate
10 be and the profitability if you did not have the one-time
11 payments in there? So the 5.8 and the 6.0 would be, I
12 think, about -- at least, what, a percentage and a half
13 worse, something like that?

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

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

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

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

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

1 they pulled back on this year.

2 And so the thinking, then, on the recommendation
3 on the next page, if I've got this right, is that the one
4 percent that would be recommended, really -- you're not
5 recommending an offset on top of that. That is one percent.
6 So you're kind of thinking, well, the statue is 1.8. The
7 0.8 that is left on the table, you'll net it into this and
8 the recommendation is one percent and no more offsets in
9 effect, right? That's what this says?

10 DR. STENSLAND: That's correct.

11 MR. BUTLER: Okay.

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

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

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

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

19 So is that clearer for people? Okay.

20 Kate, clarifying questions.

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

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

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

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

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

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

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

1 "relatively."

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

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

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

1 30 percent waste, and then they'd say, okay, how do you
2 really know it's 30 percent, and it gets very sticky to the
3 point where I would -- I doubt I could do a good job at it.
4 I think I can tell you who's relatively efficient. Telling
5 you who's absolutely efficient, we could try, but I think I
6 would fail.

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

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

22 DR. NERENZ: Yeah, just --

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

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

11 DR. SAMITT: So my questions are about Slide 4,
12 hospital capacity. So in the advance materials that we
13 read, Figure 1, by my count, there has been a net new add of
14 70 hospitals in the last five years. And so my question is
15 aimed at not whether there is too little capacity but
16 whether there's too much capacity and whether we've ever
17 really done an analysis of overall hospital bed capacity
18 nationally, essentially. As we try to make a determination
19 of capacity, do we have a targeted number that says we would
20 be concerned about hospital capacity if we achieved a
21 certain level of bed availability nationwide? I think that
22 that would be a critical factor for future adjustments to

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

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

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

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

18 MR. HACKBARTH: Yes.

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

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

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

6 DR. STENSLAND: That's correct.

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

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

15 DR. STENSLAND: It's staffed beds.

16 DR. SAMITT: Staffed.

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

19 DR. SAMITT: Thank you.

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

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

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

13 MR. GEORGE MILLER: Okay. So --

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

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

17 DR. STENSLAND: Okay.

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

1 that number do you think plays into that analysis?

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

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

11 DR. STENSLAND: I think a lot -- maybe it was that
12 18 percent of physicians are employed by hospitals? A lot
13 more than 18 percent of hospitals are employing physicians.
14 There's a lot of hospitals that have physician employees.

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

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

5 DR. STENSLAND: Correct.

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

9 MR. HACKBARTH: No.

10 MR. GEORGE MILLER: No?

11 MR. HACKBARTH: Your point is correct --

12 MR. GEORGE MILLER: Yes.

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

15 MR. GEORGE MILLER: Median.

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

20 MR. GEORGE MILLER: With that knowledge?

21 MR. HACKBARTH: With that knowledge.

22 MR. GEORGE MILLER: Yeah.

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

4 MR. GEORGE MILLER: I saw that, yeah.

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

7 MR. GEORGE MILLER: Yeah. All right.

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

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

18 DR. STENSLAND: Are you --

19 MR. GEORGE MILLER: -- on total payments?

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

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

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

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

9 MR. GEORGE MILLER: Right.

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

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

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

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

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

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

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

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

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

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

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

13 MR. GEORGE MILLER: Right.

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

15 MR. GEORGE MILLER: Exactly.

16 MR. HACKBARTH: Right.

17 MR. GEORGE MILLER: Yeah.

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

22 DR. STENSLAND: Yeah.

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

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

9 MR. HACKBARTH: Yeah.

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

14 MR. HACKBARTH: Yeah. Okay.

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

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

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

7 MR. GEORGE MILLER: Right. Right.

8 MR. HACKBARTH: And from the standpoint of --

9 MR. GEORGE MILLER: It still means less money.

10 DR. MARK MILLER: No.

11 MR. GEORGE MILLER: No? All right --

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

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

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

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

5 MR. GEORGE MILLER: That's the point.

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

8 MR. GEORGE MILLER: Right.

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

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

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

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

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

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

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

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

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

22 DR. MARK MILLER: I see --

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

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

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

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

1 DR. HALL: That's what I thought.

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

8 DR. HALL: Okay. Thank you.

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

19 The second piece is in the document itself on page
20 11, you refer to post-acute services is the one area in this
21 bucket where services have actually declined more than 1
22 percent. Could you tell or in the future describe what that

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

6 Thanks.

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

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

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

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

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

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

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

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

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

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

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

9 DR. HOADLEY: Yeah, I just have two questions.

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

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

1 DR. HOADLEY: Okay.

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

6 DR. HOADLEY: Okay. That's helpful.

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

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

18 DR. HOADLEY: Okay.

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

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

4 DR. HOADLEY: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. MARK MILLER: [off microphone].

21 [Laughter.]

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

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

5 [Laughter.]

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

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

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

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

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

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

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

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

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

1 increase in outpatient observation cases.

2 DR. COOMBS: Right.

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

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

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

19 DR. COOMBS: Thanks.

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

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

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

8 DR. COOMBS: Okay. Thank you.

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

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

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

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

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

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

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

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

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

7 MR. HACKBARTH: Cori, clarifying questions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MR. KUHN: Thank you.

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

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

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

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

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

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

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

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

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

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

3 DR. MARK MILLER: All right. Here's the quick
4 answer, and Jeff, keep track of this. The quick answer is
5 they continue, and they can be stopped by taking a portion
6 of this and saying, okay, here's a permanent adjustment to
7 stop the ongoing overpayment. So let's say that happened
8 tomorrow. There's still an \$11 billion, between 2010 and
9 2012, if I remember my numbers right, that has not been
10 recovered, and the agency statutorily doesn't have the
11 authority to go get it.

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

16 MR. HACKBARTH: [Off microphone.]

17 DR. NERENZ: [Off microphone.]

18 MR. HACKBARTH: Yeah.

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

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

1 The other thing is recovering past overpayments. Most of
2 that probably hasn't been done. We've recovered the 2008
3 and 2009 overpayments. We haven't recovered 2010, 2011,
4 2012, 2013.

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

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

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

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

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

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

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

9 MR. GEORGE MILLER: Sure. No.

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

12 MR. GEORGE MILLER: George.

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

14 [Laughter.]

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

17 [Laughter.]

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

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

21 DR. MARK MILLER: -- to my staff.

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

1 DR. MARK MILLER: Exactly.

2 [Laughter.]

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

6 DR. STENSLAND: Right.

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

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

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

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

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

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

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

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

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

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

22 Also, given what we said at the very beginning in

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

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

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

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

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

18 DR. HOADLEY: Okay.

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

21 MR. HACKBARTH: Scott.

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

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

3 I think the difficulty with that is I believe a
4 \$117 billion spend on acute care services is too much, and
5 yet making this decision isn't the way you effect that. In
6 an efficient system, we wouldn't be spending that kind of
7 money on hospital services. So that's, I think, a little
8 bit of a frustration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 which is not ideal.

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

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

22 So I'm supportive of these recommendations.

1 MR. HACKBARTH: Okay. Thank you all.

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

4 [Pause.]

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

8 Just a little bit of background. Outpatient
9 dialysis services are used to treat most patients with end-
10 stage renal disease. In 2011, there were about 365,000
11 Medicare fee-for-service dialysis patients, roughly 5,600
12 facilities. Medicare spending total for this section in
13 2011 was \$10.1 billion.

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

1 2014.

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

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

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

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

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

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

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

1 the final rule was about 0.3 percent was distributed in
2 2011. However, CMS did finalize in the final rule for the
3 2013 payment system, and they have adjusted the outliers'
4 threshold levels. So we will continue to monitor how this
5 policy is working.

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

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

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

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

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

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

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

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

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

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

4 So using 2009 to 2011 claims data, here you see
5 our preliminary analysis of the changes in erythropoietin
6 use for free-standing dialysis facilities between 2009 and
7 2011. We measured dose per beneficiary per week. Per
8 capita use was generally steady in 2009, started to decline
9 roughly in August of 2010, and has continued to decline in
10 2011. Between 2010 and 2011, per capita use declined by 18
11 percent.

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

14 First, clinical evidence has shown an association
15 between higher ESA use and adverse cardiovascular outcomes;
16 this resulted in a change to the drug's label by the FDA in
17 2011. Indeed, the FDA, in 2011, issued a modified dosing
18 recommendation calling for more conservative ESA dosing for
19 this drug class, and the FDA recommended that providers use
20 the lowest dose in order to avoid a blood transfusion.

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

1 method, when facilities were paid per unit of drug
2 administered, they did not have a strong incentive to
3 control costs of separately billable drugs. Now that
4 dialysis drugs are included in the prospective payment
5 system, facilities have a greater incentive to be more
6 efficient. In your briefing material, we also include
7 findings from researchers, working on behalf of Health and
8 Human Services, that have found a decline between 2010 and
9 2011 in the use of other dialysis injectable drugs,
10 specifically injectable iron agents that are also, along
11 with epo, used to treat anemia, and injectable vitamin D
12 agents. Two slides from now we are going to discuss the
13 effect of this trend in anemia drug utilization on dialysis
14 quality. If this trend in the declining use of dialysis
15 drugs continues and we see provider profitability improving,
16 we may at some point want to reconsider the level of the
17 base payment rate.

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

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

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

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

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

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

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

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

22 Moving to the 2013 projection, we projected at 3

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

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

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

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

22 That concludes the presentation, and I look

1 forward to your discussion.

2 MR. HACKBARTH: Okay. Thank you, Nancy.

3 Could I get you to put up Slide 14 for a second?

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

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

1 anticipated.

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

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

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

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

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

1 much further down might you project this could go?

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

9 DR. HOADLEY: There is more room --

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

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

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

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

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

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

11 DR. HOADLEY: Okay.

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

17 MS. RAY: Four [off microphone].

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

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

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

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

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

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

15 DR. NAYLOR: A zero update, no --

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

18 DR. NAYLOR: Got you. Thank you.

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

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

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

12 MS. RAY: Yeah, it --

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

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

17 DR. HALL: Thank you.

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

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

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

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

18 DR. SAMITT: Thank you.

19 MR. KUHN: Two or three quick questions here. One
20 is on the issue that came up earlier on the transition, with
21 93 percent going in in the first year and 7 percent going
22 through the four-year transition, has any of that additional

1 7 percent said we want to go all in now, or are they
2 continuing through the four-year transition?

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

5 MR. KUHN: Gotcha.

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

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

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

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

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

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

11 MS. RAY: Right.

12 MR. KUHN: Okay.

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

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

20 MS. RAY: Right.

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

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

3 MR. KUHN: Okay

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

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

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

1 And that is what --

2 MR. KUHN: Right. Is the hold up.

3 MS. RAY: -- is the hold up.

4 MR. KUHN: Okay, thanks.

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

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

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

1 indicators to think about that would detect the quality
2 here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 DR. REDBERG: Excellent report.

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

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

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

8 MS. RAY: I think the use of peritoneal -- I think
9 the declining use of peritoneal dialysis beginning in the
10 1990s, up until fairly recently, I think it's been multi-
11 factorial. I think part of it is patients are not informed
12 their treatment options even before they start dialysis and
13 after dialysis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 DR. NAYLOR: As am I.

18 DR. HALL: I am happy with it.

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

22 I am a little concerned, and I guess the question

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

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

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

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

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

22 MR. HACKBARTH: To the extent the concern is that

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

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

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

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

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

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

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

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

10 MR. HACKBARTH: Yes. Craig.

11 DR. SAMITT: Great job, Nancy.

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

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

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

5 But different discussion for a different day.

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

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

16 DR. NERENZ: [off microphone.] Yes.

17 MR. HACKBARTH: Kate?

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

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

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

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

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

14 MR. KUHN: Yes, I support the recommendations.

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

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

22 But I think this is also an area that is

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

4 DR. DEAN: I support the recommendation.

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

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

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

19 Scott.

20 MR. ARMSTRONG: I support this, too.

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

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

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

5 We will now have our public comment period.

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

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

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

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

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

22 Numerous indicators suggest that patients are

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

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

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

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

21 Thank you.

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

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

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

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

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

22 The facts support this. Even though most

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

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

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

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

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

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

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

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

14 Thank you.

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

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

19

20

21

22

1 current rate.

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

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

7 MS. BLONIARZ: The Medicare sequester starts in
8 2013, in February, and cuts 2 percent from nearly all
9 provider payments. This chart is supposed to represent how
10 it would work for an example sector.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 [Laughter.]

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

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

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

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

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

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

21 Every year, we contract for a telephone survey of
22 8,000 Medicare beneficiaries and insured individuals age 50

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

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

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

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

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

4 Another question of interest from our survey is
5 how often individuals face problems finding a doctor. In
6 2012, a very small share of respondents were looking for a
7 new physician: 7 percent of Medicare beneficiaries were
8 looking for a primary care doctor, and 13 percent were
9 looking for a specialist.

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

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

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

1 the 38 measures in the measure set, between 2008-2009 to
2 2010-2011, 20 were unchanged, 12 improved, and 6 declined.
3 The increases and decreases in quality were small. A number
4 of cancer screening measures declined slightly, which also
5 matches findings in a survey of private insurance plans, and
6 is likely due to ongoing questions on the frequency and
7 efficacy of cancer screening. One potentially avoidable
8 hospitalization measure -- for hypertension -- also worsened
9 slightly.

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

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

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

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

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

1 1.1 percent.

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

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

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

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

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

1 are discussed further in the draft chapter.

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

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

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

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

1 services.

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

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

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

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

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

12 The equity of payments under the fee schedule is
13 another issue that the Commission has been concerned about.
14 In addition, some physicians assert that they lose money
15 when furnishing services to Medicare patients. Looking at
16 physician compensation data for 2010, we see that actual
17 annual compensation for primary care physicians averaged
18 \$207,000. By contrast, actual annual compensation for
19 physicians in non-surgical procedural specialties averaged
20 \$445,000. Simulating compensation as if all services were
21 paid under Medicare's fee schedule, the disparity remains:
22 \$170,000 for primary care and \$398,000 for the non-surgical

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

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

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

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

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

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

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

22 This year, for the update for physician and other

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

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

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

22 In addition, 90 percent of ASCs have some degree

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

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

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

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

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

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

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

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

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

1 and aggregate Medicare payments to ASCs.

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

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

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

1 services in hospitals rather than ASCs.

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

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

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

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

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

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

7 Next slide, please.

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

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

22 If cost data were to be collected, they could be

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

4 Next slide?

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

9 Next slide, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 DR. COOMBS: Thank you.

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

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

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

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

20 MR. HACKBARTH: So, let me pick up on that. What
21 we do in this survey is 4,000 Medicare beneficiaries and
22 4,000 privately insured patients in the age group just

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

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

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

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

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

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

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

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

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

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

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

12 DR. DEAN: [Off microphone.] Okay.

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

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

8 Cori.

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

15 MS. BLONJARZ: I don't know that we know. We
16 could think about it.

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

22 Also, just generally, people have less problem

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

6 MS. BLONIARZ: I think --

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

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

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

18 MS. BLONIARZ: Right.

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

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

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

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

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

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

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

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

20 MS. UCCELLO: Is that -- okay.

21 MR. HACKBARTH: Yeah. Herb.

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

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

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

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

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

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

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

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

1 not all that different.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 care access going forward.

2 [Off record discussion.]

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

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

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

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

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

13 And so about two years ago, we did try to look at
14 whether an existing input price index in Medicare, like the
15 hospital market basket or the practice expense component of
16 the MEI, would be a better proxy for ASC costs than the CPI,
17 and we found in some ways ASCs have a different cost
18 structure than hospitals and physician offices. We were
19 using pretty old cost data that had been collected by GAO in
20 2005. So, you know, it wasn't really ideal for creating a
21 new price index or even accurately measuring ASCs' cost
22 structure. But it did provide some indication that their

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

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

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

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

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

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

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

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

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

10 DR. HAYES: No, and there is, you know, a table --
11 [Laughter.]

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

1 intensity for those visits. Okay?

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

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

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

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

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

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

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

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

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

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

13 DR. SAMITT: Fair enough.

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

16 MR. HACKBARTH: Clarifying questions [off
17 microphone].

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

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

21 [Laughter.]

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

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

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

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

11 Thank you.

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

18 MS. BLONJARZ: So the list of the measures are at
19 the end of the paper.

20 DR. NAYLOR: Right.

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

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

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

5 MS. BLONJARZ: Not that I'm aware of.

6 DR. NAYLOR: Okay.

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

13 DR. NAYLOR: My second question is: Last year in
14 the report, we had a really good sense of the 300,000 of
15 850,000 physicians and other health professionals, the
16 300,000 that are not physicians, of how much they were
17 contributing to primary care. I recall a third were either
18 the primary source of primary care or on the group of
19 providers. So do we have a sense from this work now about
20 the contribution of other health professionals to the
21 primary care?

22 MS. BLONJARZ: We have some stuff from the survey

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

4 DR. NAYLOR: Thank you.

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

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

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

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

9 Anything to add to that?

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

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

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

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

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

14 [Laughter.]

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

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

18 DR. MARK MILLER: It's in discussion.

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

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

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

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

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

18 MR. ARMSTRONG: Okay.

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

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

1 knowing whether the OPD volume would go down?

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

3 MR. ARMSTRONG: Okay.

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

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

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

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

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

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

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

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

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

12 DR. COOMBS: Right.

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

17 DR. COOMBS: Okay.

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

19 DR. COOMBS: Right, right.

20 MR. WINTER: Okay.

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

1 to do a value-based --

2 DR. COOMBS: Right. And I support it.

3 MR. HACKBARTH: Okay.

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

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

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

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

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

1 health care literacy concerns, and so I think it's -- the
2 access issues is so complex that, you know, before we walk
3 away from the table and say we don't have an access problem
4 -- and the point I brought up about the margin of error, if
5 you get a 75 percent concordance that you don't have
6 problems with access, and you have a large margin of error
7 and a small sample size, it's possible that it could be that
8 50 percent of the people actually have a problem. And you
9 just had this rare sample size that actually is a little
10 divergent from the general population. Is it extrapolated
11 to the general population of Medicare patients?

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

17 DR. COOMBS: Exactly

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

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

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

7 MR. HACKBARTH: Right.

8 DR. COOMBS: And so I would actually go back and
9 do a much more clarifying survey about actual time -- time
10 to see doctors. And I don't know if that's possible, but
11 that's the kind of information that you really want about
12 access. Not a yes-no, not, oh, a little, small problem,
13 somewhat, or that kind of thing. I think that you kind of
14 want to know, well, does it take you eight weeks to see a
15 doctor? It may be okay for patients to say, "That's not a
16 problem for me. I can wait eight weeks," when indeed maybe
17 eight weeks is too long.

18 DR. BAICKER: Just a point on that question. I
19 know it would be very labor-intensive to do another survey
20 or to modify this survey going forward. There are a number
21 of other surveys that ask questions like that of different
22 sets of people where you couldn't do direct links and you

1 couldn't necessarily break down the same populations, but
2 maybe you could see if they're measured in enough geographic
3 -- fine enough geographic detail, you could see do the
4 measures that you're using here correlate reasonably well
5 with some of those other measures to get a sense of whether
6 you're -- you know, almost a factor analysis. Are you
7 pulling out something real? Or are there important
8 components of true access that aren't captured very well by
9 these measures? And I think we would all have a sense of
10 security in our measures of access if there were reasonable
11 concordance across these different modes of asking, because
12 there are surveys that ask about how long does it take you
13 to get an appointment, and plan performance surveys that say
14 are you satisfied with the quality of information you're
15 getting from your provider or the quality of time you're
16 spending with your provider, and those might capture the
17 more nuanced sense that we're all looking for.

18 MR. HACKBARTH: So, in the interest of time, I
19 think I understand that, and let's maybe have a conversation
20 here and pursue this angle of looking at whether -- other
21 sources of data that may shed light.

22 DR. COOMBS: And I appreciate, Glenn, the fact

1 that we're all around this table, I think everyone is
2 concerned about this, but to get our arms around what really
3 is good access versus complicated and compromised access, I
4 think, is the bottom line to how we go and how we navigate
5 through this SGR process.

6 MR. HACKBARTH: Tom, round two.

7 DR. DEAN: I certainly support the SGR
8 recommendations. I just wish there was a way to make the
9 SGR recommendations more immediate in the eyes of Congress
10 and to somehow convince them this really is a ticking time
11 bomb, because I think it's only going to get worse, and at
12 some point, we're really going to see a disaster from this.
13 But I think we've tried and we keep trying, I guess. So,
14 anyway, I support that and also the ASC recommendations.

15 MR. HACKBARTH: Cori, can I just say one thing in
16 response to Tom? So one possible reason that Congress has
17 not moved to repeal SGR is the budget problem, and I think
18 that's a really big one. I don't know what else we can do
19 on that front.

20 DR. DEAN: [Off microphone.] Right.

21 MR. HACKBARTH: A second reason is that they don't
22 share our sense of urgency about this. They don't see the

1 potential for this unraveling quickly. I'm not sure what to
2 do on that and I'm open to suggestions for how we can save
3 that in a way that makes it more compelling.

4 A third potential reason is that people believe
5 that, well, if we do another short-term fix, you know, say
6 two years, in two years, we will have a solution that won't
7 be painful for dealing with the budget problem and we'll
8 have a better physician payment system and we can just move
9 people in two years from now. People have been saying that
10 sequentially for year after year after year. I believe
11 that's a false premise, myself. I don't think there is a
12 painless solution to the budget problem.

13 I think in terms of new payment models, we've got
14 one up and running now with ACOs. Now is the time to begin
15 moving -- creating incentives for people to move in that
16 direction. I don't think -- in two years, we may have added
17 bundling around a hospital admission or a couple other
18 wrinkles, but the picture will not be dramatically different
19 in two years in terms of new payment options than it is
20 today. And to keep pushing this out into the future and to
21 hope that some new solution is going to materialize, I think
22 is mistaken. Maybe we can be more forceful in how we make

1 that point.

2 DR. DEAN: I guess that's just what I was alluding
3 to. If there is any way to state this in even stronger
4 terms than we already have, I would strongly support doing
5 it, whether it's bold print or whatever.

6 MS. UCCELLO: I agree, and I agree it's kind of
7 difficult to figure out how to stress this more. But people
8 said earlier, and Mike might say it again now, but also,
9 just kind of highlighting, again, that these options that we
10 came up with were difficult. And if their intention -- if
11 Congress's intention is to really do this by paying for it
12 through other Medicare reductions, then stressing again how
13 they can't pick things off this list and use it for
14 something else, because that's going to make this even more
15 difficult. So just, you know, if we can stress that again.

16 So I strongly support including this again,
17 stressing it as much as we can, and also, I think that ASC
18 recommendation is reasonable.

19 MR. KUHN: I'm good with rerunning the SGR
20 recommendation from a year ago. I think that makes sense.

21 Also, I'm fine with the ASC recommendation, and I
22 do appreciate, Kate and everybody else, all the good work on

1 this particular chapter, or both chapters, this and the
2 physician and ASC chapter, and particularly all the good
3 work on the access. I think we had a very good discussion
4 on that today and really good discussion in the papers.
5 Thank you for that.

6 DR. CHERNEW: So I want to, first, add my voice to
7 the general message of SGR first, meaning when we find money
8 to save, use it to fix the SGR and then we can think about
9 other things you might want to use it for. And I think, you
10 know, the money is fungible, but I think we really have to
11 support the message that the SGR has to go away, and I agree
12 with that.

13 I want to talk more about the other issues, ASCs
14 and such, and one of the challenges we have is -- which we
15 know -- is there's all of these separate services and site
16 of care can differ. We've had a lot of long discussions
17 about site of care-type things. And I think it's stunning
18 how little we know about the substitutability across the
19 services and in particular how that substitution would
20 change in response to things we would do.

21 So even though we can see trends moving one way or
22 another, there's trends and associations and there's causal

1 things. If we change an update for ASCs, you have to think
2 about that with regards to the other sites where similar
3 services could be provided, and we have updates for those
4 and how do we keep it consistent. And even if the updates
5 are moving differently, they're starting at different
6 levels. So a model of where care would go and where care
7 should go is conceptually hard, but we don't have to do that
8 because we don't have the data to fill it out anyway.

9 So we're sort of left with dark in this sort of
10 complicated way, and I think that matters, but it's relevant
11 to the comment that I'm going to make which relates to the
12 ASC recommendation.

13 So I support the ASC recommendation, not with huge
14 enthusiasm or not, but I support it because of this notion
15 that we have other things that are moving up a little more
16 that might be substitutes in how we're going to do it. But
17 there's other things that might be moving up less overall.
18 I think if it was ASCs alone, without the cost data -- my
19 personal opinion is, without the cost data and the evidence
20 that we have on the table, it strikes me that there's other
21 services that we have given lower update rates to than ASCs,
22 and I don't see that there's a problem in access to ASCs or

1 some of the other capital things. But there's a notion of
2 how we set that rate relative to other similar services and
3 I don't know how to deal with that.

4 So the end of this rambling point is, I support
5 where we are within a wide range of uncertainty, but I can
6 be convinced to support less generous updates if I were
7 looking at just ASCs alone.

8 MR. BUTLER: I'll start with the ASC
9 recommendation and say I can support it. I would like us to
10 be as precise as we can about the cost information so that
11 it's as useful a recommendation as we can make it.

12 But a couple comments on this. I know where
13 George is going to go with this, but -- so I won't trump
14 you, I promise. In looking over the last 25 years or so, I
15 think the movement to ASCs has been primarily physician-led
16 for two reasons. One, they had ownership. And second, time
17 is money, and to the extent that you had efficient
18 operations for the routine stuff, they said, this simplifies
19 my life. And so what do you think we have in those even
20 today? It's mostly, if you look at the lists, it's the
21 interocular lens, it's the pain, nerve injections, and it's
22 the simple ortho stuff, and it's pretty much stayed that

1 way.

2 So when you think about that -- and it's only --
3 only three -- \$3 billion. This isn't a huge industry unto
4 itself for the Medicare. If you look at what's happening on
5 the hospital outpatient stuff, you'd be surprised the number
6 of stuff that is flipping minimally invasive and becoming
7 overnight or close to it that really would be a whole
8 different kettle of fish than what we're talking about
9 that's in the ASC bucket right now. And that -- a lot of
10 that stuff will need to be in the hospital because you want
11 to say, okay, do I need to observe this or not, but you will
12 be flipping, actually, from an inpatient to an outpatient
13 payment within the hospital setting, which has savings by
14 itself.

15 So this isn't quite as clear as it sounds when we
16 just present the list of things that are sitting in ASCs
17 today.

18 MR. HACKBARTH: So what I hear you saying, Peter,
19 is that given trends in the delivery of care, that the
20 substitutability of ASC for HOPD for surgery may be less in
21 the future than it's been in the past.

22 MR. BUTLER: Yes. If we wanted to pursue a same

1 site kind of thing and you really did it -- it would work
2 best if you did just take, okay, fine. We'll take the eye
3 procedures, the nerve injections, and we'll take the
4 colonoscopies, endoscopies, the stuff that you could kind of
5 limit it to a --

6 MR. HACKBARTH: Right.

7 MR. BUTLER: -- non-debatable list of things that
8 says, you know what? You might save and you could -- and
9 there's no way you really need the hospital oversight for
10 those kinds of things and zero in on a set rather than
11 blanket let's just narrow the difference between the two,
12 because it wouldn't make sense for some of the things. But
13 you could for a short list. This isn't unlike our other
14 discussion on same site kinds of things.

15 Back on the SGR. There's been kind of a quiet,
16 less discussion around this than I anticipated in many ways.
17 But just so I'm clear in my mind, we kind of have up there
18 the Chairman's proposal is to restate the SGR. I don't know
19 what that means. We're not voting on anything. So we're
20 kind of talking about it, but we're kind of silent in terms
21 of any official vote on where we stand --

22 MR. HACKBARTH: That's right --

1 MR. BUTLER: -- because we've already submitted
2 the letter.

3 MR. HACKBARTH: Right. And so we would note the
4 letter, or summarize the letter, or include the letter --
5 not an appendix, because it's too long, I think, to do that
6 -- but we'd summarize the letter and then in the text we
7 would make the points that we're discussing now about the
8 urgency, et cetera, and the thinking that was behind the
9 letter.

10 MR. BUTLER: Just, in my mind, it's a little fuzzy
11 if I'm following this session and then the one in January
12 and say, what did they do with physician updates? By the
13 time they really get it, it's kind of, like, March, and --
14 oh, yeah, we have that letter that we -- and we cited it at
15 that point in time. It's a little less direct than kind of
16 saying we're restating the letter. I'm not suggesting we
17 re-vote on it, but it kind of is a little indirect way of
18 kind of saying where we sit. I'm not sure of the answer to
19 it, but I know people want to know sooner rather than later
20 where we stand and --

21 DR. MARK MILLER: And just so you know -- and I
22 think you know this, but I'll just say it out loud -- you

1 know, despite the fact that it actually gets printed and
2 published and sent out in March, and there may be people at
3 that point who read it and go, oh, that's what they did, the
4 immediate client, the committees of oversight, they know
5 immediately what our decisions are in January. And so you
6 shouldn't think that, somehow, it doesn't get communicated
7 to them.

8 MR. BUTLER: But we don't have an official
9 decision around this in terms of we voted on it.

10 DR. MARK MILLER: I understand what you're saying,
11 but come January -- or depending on how this conversation
12 terminates and January's decision terminates, we can go to
13 the Hill and say, okay, our policy is what it's been, and
14 you have this letter. Here is the letter again. You can
15 make those kinds of transactions with them. But you should
16 already know that the committees of jurisdiction know what
17 this conversation is and what is being discussed today and
18 how we're approaching it. So those people do follow what's
19 going on.

20 So, for example, I briefed them before all of
21 these meetings and I'll say, the discussion that the
22 Commissioners are going to have tomorrow is this discussion

1 -- I won't describe it, you're part of it. And I'll say, so
2 if you're thinking one year or four months, that's not where
3 the Commission is. The Commission continues to say, this is
4 the way you should approach things. You should repeal the
5 SGR. So they know that we're -- I mean, assuming the
6 outcome of this conversation, we're potentially in a
7 different position than a one-year fix or whatever the case
8 may be.

9 But you don't seem like that was the answer to
10 your question.

11 MR. BUTLER: No, the people -- you're saying the
12 people that need to know, because they follow this, and you
13 don't have to -- I'm just trying to think if you report in
14 the New York Times, the Commissioners voted on the following
15 recommendations in January, boom, boom, boom, boom, boom,
16 there wouldn't be anything listed at all for SGR. Or
17 physician updates.

18 DR. MARK MILLER: And Robert Pear is here, so he
19 knows now, so -- we got him.

20 [Laughter.]

21 DR. MARK MILLER: I see your point, the general
22 point.

1 DR. COOMBS: Glenn, just a point of information.
2 After Peter said that, it kind of jarred me. So you wanted
3 us to state whether or not we supported all of the bullets
4 that are in the SGR on this slide, is that correct?

5 MR. HACKBARTH: [Off microphone.] You're welcome
6 to.

7 DR. COOMBS: Okay. So now that Peter kind of
8 jarred me up here a little bit -- thank you, Peter -- I do
9 support the first three bullets. The last bullet, I have a
10 problem with, and I just want to go on record for that, now
11 that I know that there is some kind of official stance that
12 we have to take. Thank you.

13 MR. HACKBARTH: Let me reiterate what the last one
14 is. That is not what MedPAC is recommending. The operative
15 word there is "if." If Congress decides that it, A, needs
16 to be fully financed, and B, it needs to come from Medicare,
17 this is a series of options for them to look at to do that.
18 We neither advocated that it be fully financed nor advocated
19 that it be fully financed from Medicare. I want that to be
20 crystal clear.

21 And so the really important part of the letter, as
22 I said, the MedPAC policy point of the letter is repeal,

1 rebalance primary care versus specialty, create incentives
2 to move into new payment systems. All of the rest is
3 stylized to answer the question, if Congress says it needs
4 to be fully financed under Medicare, what are their options
5 for doing that. So nobody is asking you to endorse fully
6 financing out of Medicare. That's the point I'm trying to
7 make, okay? Are we clear?

8 DR. COOMBS: So I understand that, but I was just
9 saying that I support the first three bullets.

10 MR. HACKBARTH: Okay. We need to pick up the pace
11 here or we're going to be here until my bedtime. So Kate.

12 DR. BAICKER: So as far as the ASC recommendation,
13 I'm fine with it. I agree with Mike's perception that from
14 the data that have been presented, one might also have come
15 to a zero update conclusion and that there's enough
16 uncertainty that it's hard to differentiate between those
17 and we need better data.

18 And just to contribute to the SGR conversation,
19 I'd add to your statement of the current state of affairs
20 that, in fact, we didn't vote on the specific line items in
21 that list, that I think we had some diversity of feelings
22 about those line items, and that the message I think we all

1 agreed to was there's some painful stuff has to happen if
2 you're going to do it from within the Medicare budget and
3 that a combination of potentially painful approaches would
4 be necessary. Which among that menu we would choose, I
5 think we probably had some very different ideas about. Nor
6 are we recommending any particular subset of those menus.
7 But I think it was really helpful to lay out, like, here are
8 the kinds of things you have to do. Here are the price tags
9 associated with them. If you're going to choose, you're not
10 going to be able to pick some easy low-hanging fruit. It's
11 going to be something substantial from this list.

12 But I want to just be clear that even in the world
13 in which it's all getting financed from Medicare, which we
14 are not suggesting is the outcome we desire, there's still a
15 lot of room for debate within that list and it's clearly not
16 going to be easy but just gets more painful over time and
17 has to get done.

18 MR. HACKBARTH: And thanks for that, Kate. I
19 agree with all that.

20 Now, in point of fact, we have gone back on some
21 of the specific items on that list and formulated them as
22 specific recommendations on which we voted after we did more

1 analysis and the like.

2 Dave.

3 DR. NERENZ: Okay. I'm generally fine with the
4 recommendations.

5 If we could go back to Slide 16, just a couple of
6 brief points about that, and this is SGR again. My first
7 observation is that I understand -- I really appreciate your
8 discussion about this constraint and how this was that if it
9 had to be done this way, here is what we would do.

10 In reading the October of last year letter and
11 looking at our materials this morning, I think, at least in
12 my mind, a false impression has been created that the
13 constraint is even tighter than you declared, meaning it
14 appears, incorrectly, that this is being done within the
15 physician payment segment of Medicare, only in the sense
16 that -- and there's some people who are nodding -- I know
17 that's not correct, but I'm just saying, as we present this
18 material, simply because we've created a direct link in the
19 discussion between SGR and the particular recommendations
20 about physician payment. I have seen less clear connection
21 between SGR and the other things.

22 And I just was re-reading again the October 2011

1 letter. Almost all of the text is about a connection
2 between SGR and specific physician payment recommendations.
3 The rest is in an appendix. Now, it's there. I understand
4 it's there. But I'm just suggesting, if we're refreshing
5 this, we may bring some of those other things more forward
6 just to create what I think is a more accurate impression
7 that our view of SGR is about more than just SGR to
8 physician payment. It's SGR to a set of elements of
9 Medicare payment. Okay. So just support of that.

10 And then the third major bullet up there, in
11 support of that idea, we have said a couple times that we
12 are intending in some cases to create some uncomfortableness
13 or some incentives to move away from fee-for-service
14 payment. I think we've often been less clear about what we
15 want people to move to. So I think when those opportunities
16 arise, and that would be -- the third bullet here would be
17 an example -- or then Scott hinted at it a while ago, about
18 what if you increased payment to ASCs, when we have the
19 opportunity to say, here is something that we could do that
20 would be an incentive to draw people to something, we should
21 just be as strong and clear as we can about that, as well.

22 DR. SAMITT: So I support the ASC recommendation

1 and I have nothing else to say about that at this point.

2 My remarks are purely about the SGR. I have
3 admittedly had a hard time getting my head around why this
4 is such a hard decision to make. For me, it seems as if
5 there are three options. Either we don't repeal the SGR, is
6 option one, and I think we all recognize that that is
7 disastrous, and living in the world that I live in, this
8 will clearly result in a long-term and short-term access
9 problem.

10 Option two is to repeal the SGR, but not now, and
11 wait at some point into the future, and what you've
12 highlighted, Glenn, back to your story of 2001, is we only
13 exacerbate the cost -- in fact, it's exponential -- for
14 every year that we don't fix this problem.

15 And then, obviously, the third scenario is to
16 repeal the SGR and to repeal it now. And so I have a hard
17 time understanding why we wouldn't pick that path.

18 I would go so far as to say, and I know that it's
19 not our place to recommend how the SGR fix is funded, but
20 for me, there's a golden opportunity right now, which is if
21 Congress does decide to fix the SGR through internal funding
22 from the Medicare program, that creates the exact incentive

1 that we need to encourage providers to move toward
2 alternative forms of payment. So if the alternative is to
3 live in the fee-for-service world with declining unit-based
4 reimbursement because that's the way the SGR cut will be
5 funded versus pursuing an alternative, which would be
6 bundled payments or value-based payments, what better moment
7 than now to instigate that transformation than to do exactly
8 that.

9 MR. GEORGE MILLER: Well, first of all, let me say
10 that Craig teed up very nicely the whole notion that we
11 need to look at an alternative method of payment for the
12 entire health care program so we can stop the issue of
13 dealing with silos, because we sometimes pit side against
14 side trying to protect one silo versus others. So let me do
15 -- let me move on to what Peter teed me up.

16 I am really concerned -- I support and helped
17 restate the SGR recommendations. I have a problem with
18 recommending additional funding for ASC, and let me tell you
19 why. In the material, and I thank the staff for providing
20 the material, there's some very clear differences
21 demographically in the material about the access to care for
22 dual eligibles, for Medicaid populations, and for

1 minorities. That troubles me very deeply. The numbers are
2 irrefutable. They are very stark and I just have a major
3 problem of recommending additional funding, particularly
4 because we don't have cost data. We picked on and have
5 discussed the HOPDs, but there's cost data, and I understand
6 the rationale.

7 What I have not heard in this discussion about all
8 of these issues is -- and for me, it's the stand-by
9 capacity, dealing with hospitals -- there is a cost for that
10 stand-by capacity. I don't know if we've ever done an
11 analysis of what it costs to have that stand-by capacity,
12 how much of it is unfunded mandates. And then we compare
13 other settings to provide care and say, well, their HOPD
14 should be paid the same level for care because they don't
15 have that stand-by capacity.

16 Anecdotally, I can remember three natural
17 disasters that happened and our hospital and other hospitals
18 sent folks to help, and partly we're able to do that because
19 of stand-by capacity.

20 But getting back to the central point, today,
21 there's no cost data for ASCs. My major problem, again, is
22 the access issue with those three groups I say are not well

1 represented at all with the ASCs. And again, as Peter
2 indicated, there's no CHF-type ASCs in America or pneumonias
3 or congestive heart failure centers. There is a reason ASCs
4 are there, and maybe they need to be there, but there's a
5 specific reason they are there and my problem is they don't
6 serve the entire Medicare population.

7 MR. HACKBARTH: George, what would be your
8 preference to do with the ASC update? Zero update or a
9 reduction?

10 MR. GEORGE MILLER: At the most, a zero update.
11 At the most.

12 MR. HACKBARTH: Okay.

13 Just one clarification, I think it's Ariel or Dan
14 that I'm directing this to.

15 ASCs now use a patient classification system like
16 is used for hospital outpatient departments, but the
17 conversion factor is different. What is the difference
18 between the conversion factor for ASCs versus HOPDs?

19 DR. ZABINSKI: The conversion factor itself is 73
20 percent higher in HOPDs.

21 MR. HACKBARTH: 73 percent higher? We pay ASCs 73
22 percent of the rate that we pay --

1 DR. ZABINSKI: No. The HOPD rate -- flip side.

2 DR. MARK MILLER: [off microphone.] Express it
3 the way he wants it.

4 DR. ZABINSKI: 57 percent.

5 MR. HACKBARTH: Okay. So we pay ASCs 57 percent
6 of the rate paid to HOPDs for the same service. I just
7 wanted to make sure you understood that.

8 MR. GEORGE MILLER: Yes, I got it.

9 MR. HACKBARTH: Bill.

10 DR. HALL: I remain supportive of our SGR
11 recommendations and also the ASC recommendations.

12 And just very briefly, for the record, the
13 arguments that have been coming forward in the public about
14 the gravity of the SGR situation oftentimes are expressed in
15 terms of what this will do to physician and other health
16 care providers, in terms of being able to cover their
17 expenses to continue to provide services.

18 And I think there's a tendency to think well,
19 these are people who are not too bad off financially to
20 begin with, what's the big deal here? I think the really
21 grave and serious issue is that once we deprive older
22 Medicare recipients of access to primary care, it's not a

1 neutral event. Bad things happen. They flood our emergency
2 rooms with chronic illness exacerbations that could have
3 easily been preventable. They take either too many or not
4 enough drugs or the wrong drugs. They keep going and they
5 fall down.

6 They're a little bit like people on the
7 unemployment list. They come off the list because they stop
8 trying to get health care. Their expectations tend to be
9 much less demanding as, say, 20-year-olds who don't have
10 health insurance.

11 I think that's the real issue and that's really
12 what we should be about in this Commission, and we are, of
13 course.

14 DR. NAYLOR: Briefly, this was really another -- I
15 guess, ditto, excellent report all around.

16 I also appreciated the issues and attention on
17 access reinforced by multiple other surveys which, I think,
18 helped us to understand what the challenges are.

19 I support the urgency of acting on SGR and maybe
20 only recommend one tweak in the recommendation, that we say
21 that our action is to ask Congress to implement the
22 recommendations of....et cetera.

1 On ASC, I would support the Chairman's
2 recommendation. Two minor suggestions, in terms of the
3 chapter itself is to really capture the robust workforce
4 that's evolving for primary care as I've described; and also
5 to explore the possibilities of continued development in the
6 quality measures that reflect less a process and doing
7 things and more of what we want as outcomes.

8 Thank you.

9 DR. HOADLEY: On the ASC, I can support the
10 recommendation. Like a couple of people, Mike and Kate and
11 George have talked about I could also support a zero update.

12 I think, as Alice first raised, putting the value-
13 based purchase program language back in, or at least
14 referring in a clear way to it again, is probably useful.

15 On the SGR stuff, I certainly can support the
16 direction of these policies. And maybe what's interesting
17 in the conversation today is a number of different ideas
18 about ways that in the text or in testimony or wherever,
19 sort of some of the reframing work, reemphasizing the
20 issues. The way you've stated it a couple of times, the big
21 three principles.

22 Mike talked about despite all of the things that

1 we've looked at about access and saying that the anecdotes
2 of access problems aren't necessarily supported by the data.
3 You can't assume that that further will continue if we're
4 talking about a substantially different level of payment.
5 And anybody that anybody wants to link sort of our findings
6 of what's happening today as we've been basically stable in
7 payment, that's not a fair extension from what we found on
8 that.

9 And some other things that I don't need to repeat.

10 MR. ARMSTRONG: I, too, support the
11 recommendations for the ASC payment changes.

12 And on the SGR, I want to affirm that I think in
13 my tenure as a Commissioner, that's the best work we've
14 done. I strongly support it. I actually happen to believe
15 that the cost of repealing the SGR should be borne by the
16 Medicare program. I realize that's not a recommendation but
17 that's my personal point of view.

18 I thought Craig's point was excellent, that it is
19 a great piece of work and it could be even more impactful if
20 it gets implemented and it creates an opportunity to really
21 move changes in our payment policy towards some of the goals
22 that it outlines.

1 The last point I would make is that our issue with
2 the SGR recommendation is that there were a lot of ideas in
3 there that we had already been discussing in the context of
4 other chapters or other topics. It may be worthwhile in
5 January to just check to make sure that some items on that
6 list are not already counted on, or the status of all that
7 stuff is still consistent with what we assumed it was in
8 October of 2011.

9 DR. REDBERG: I passed on the clarifying questions
10 because I just wanted to make a few comments related really
11 to the overall theme. Looking at our quality measures
12 because whenever we make changes we want to be sure we're
13 ensuring quality, I just would point out that I think we
14 could use more quality measures looking at overuse. Because
15 right now we're looking at, for example, breast cancer
16 screening. But how about quality measures that you're not
17 getting mammography more often than you're supposed to?
18 That we're not doing mammography in women over 85, that
19 we're not doing pap smears in women who don't have a uterus
20 -- or a cervix, that we're currently doing.

21 Basically the U.S. Preventive Services Task Force
22 makes some clear recommendations but Medicare pays for a lot

1 more cancer screening that is not in the interest of our
2 beneficiaries.

3 And so I would, when we are thinking about
4 reorganizing, think about overuse measures and appropriate
5 use measures. Because the other big pocket we looked at was
6 imaging. I was actually surprised because when you showed
7 us the decrease in imaging, all of my colleagues in
8 cardiology have been saying look at this, our imaging is not
9 going up. But if I understood correctly, it's not that it's
10 not going up, it's just going up in the outpatient setting
11 and it's not going up where it's now reimbursed less.

12 And certainly, I think a lot of that imaging is
13 not going towards better patient outcomes. There's clearly
14 been a big increase in imaging. Some of our Medicare
15 beneficiaries are now getting as much radiation as Hiroshima
16 survivors. So I think that we really need to look at
17 appropriate use of Medicare services when we're looking at
18 the bigger picture.

19 With regard to our specific recommendations here,
20 I support the SGR recommendations. I think if we don't
21 repeat it now, we're just going to be sitting here in 10
22 more years and it's going to be even more expensive. It's

1 clearly never going to work. I support the recommendations
2 to repeal.

3 I also support the ASC update and agree with -- I
4 would support the Chairman's recommendation, although I
5 could go lower, as well.

6 MR. HACKBARTH: So as we've gone through the
7 latter stages of this, I've been thinking about the SGR
8 message and ways to maybe just sharpen it a little bit to
9 reflect this conversation.

10 Mike suggested the idea of SGR First ought to be
11 our message. Don't continue to use Medicare savings for
12 other purposes while just kicking the can down the road on
13 this. That's another way of creating more focus, more
14 urgency about fixing this now.

15 Anybody have a problem with SGR first as part of
16 our message here? It seems consistent with the themes that
17 I heard. Bill?

18 DR. HALL: As long as we nuance it in terms of the
19 benefit to the Medicare recipient, not the health care
20 provider. I think that's a very important -- that's the way
21 we should do it.

22 MR. HACKBARTH: Yes. SGR first in the name of

1 assuring adequate access to care for Medicare beneficiaries.

2 DR. HALL: And ultimately saving health care
3 dollars.

4 MR. HACKBARTH: Yes.

5 DR. BAICKER: I think one wants to be a little
6 careful in thinking about first relative to what else.
7 There are all these things that we said are important, and
8 we don't want to verge into the territory where we don't
9 belong of trying to optimize across Medicare and other uses.
10 And SGR first, while I think individually we might think is
11 a great idea, there's a risk in making it sound like we're
12 saying at the expense of other programs or other -- it's a
13 little dangerous.

14 MR. HACKBARTH: So we'll think some more about how
15 to formulate that but I just wanted a quick test of whether
16 that rang a bell for people.

17 Okay, thank you all. I appreciate your great work
18 on this.

19 Next up is skilled nursing facility payment.

20 [Pause.]

21 MR. HACKBARTH: Whenever you're ready, Carol.

22 DR. CARTER: Okay. We're going to be spending the

1 rest of the meeting focusing on the adequacy of Medicare's
2 payments for post-acute care. This is work we are required
3 to do, and it is important for ensuring beneficiary access
4 to high-quality care.

5 But before I get started, I wanted to remind you
6 of the second body of work that looks across silos. Much of
7 this work examines broad reforms aimed at matching patients
8 who need post-acute care to the settings that provide the
9 best outcomes at the lowest cost. The Commission pursues
10 both bodies of work, acknowledging that each is critical to
11 the success of the program.

12 Just first, a definition. When we talk about
13 post-acute care, we are referring the providers listed on
14 this slide.

15 Our work on payment accuracy focuses on ensuring
16 that payments are adequate to cover the costs of an
17 efficient provider, but not too high that the program incurs
18 unnecessarily high spending. We refer to this as the level
19 of payment. In some sectors we see significant variation in
20 provider costs that are not explained by differences in the
21 patients they treat. In SNFs and home health agencies, we
22 have found a set of relatively efficient providers that

1 restrain their costs and furnish high-quality care while
2 maintaining high margins. We plan to expand our efficient
3 provider work to other PAC sectors.

4 Beyond this look at the level of payments, we
5 consider the distribution and whether there are systematic
6 biases within each payment system that result in paying too
7 much for some services and not enough for others. Poorly
8 distributed payments encourage the selection of some
9 patients over others and the provision of certain services,
10 even when they are not necessary. This work often leads to
11 recommended changes to the payment systems.

12 Another strand of work looks at program integrity
13 issues, such as utilization patterns that raise questions
14 about whether services met coverage rules. In home health
15 care, this work resulted in a recommendation to conduct
16 medical reviews in counties with unusual service use.

17 We have identified several shortcomings in post-
18 acute care that cut across settings and undermine the
19 efficiency in delivery of care. The first is that post-
20 acute care is not well defined, and the need for these
21 services is not always clear. Some patients can go home
22 without it, and others need it but receive varying amounts.

1 Another problem is that settings overlap in the services
2 they furnish and the patients they treat, yet Medicare pays
3 very different rates depending on the setting.

4 For example, patients recovering from strokes are
5 treated with home health care and in IRFs and in SNFs, and a
6 small share are also treated in LTCHs. The quality and
7 patient outcomes cannot be compared across the settings
8 because there is no common patient assessment instrument.
9 And, finally, there are no incentives to encourage care
10 coordination between providers or safe transitions home.

11 Appreciating the limits of the FEE-for-service
12 world, we have conducted work on at least four broad payment
13 reforms that encourage getting beneficiaries the right
14 services at the right time for the right price. These
15 reforms include bundled payments and accountable care
16 organizations; a common patient assessment instrument; the
17 development of risk-adjusted, outcomes-based quality
18 measures; and the alignment of readmission policies across
19 settings.

20 Bundled payments and ACOs are reforms that create
21 larger units of service, in the one case for all post-acute
22 care following a hospitalization, and in the other for

1 assuming responsibility for a population. In both,
2 providers have an incentive to get patients to the right
3 services at the right time, coordinate their care, and use
4 resources efficiently. The Commission recommended testing
5 bundled payments back in 2008, and we have ongoing work on
6 PAC bundles. We also commented on the proposed rules for
7 ACOs and continue to monitor their progress.

8 The second broad reform work focuses on whether to
9 require PAC providers to use the same patient assessment
10 tool. Back in 2005, the Commission called for such a tool
11 so that all patients, their service use, and outcomes could
12 be compared across settings. CMS completed a mandated
13 demonstration of a common assessment tool in 2005. It found
14 that such a tool was feasible, and its analysis of resource
15 use indicated the potential for a single payment system
16 across institutional settings.

17 The Commission has also focused some of its work
18 on developing risk-adjusted, outcomes-based measures of
19 post-acute care so that the efficacy of settings can be
20 assessed. Given the goal of much post-acute care is to go
21 home, we have developed risk-adjusted rates of discharge to
22 the community for SNFs and IRFs. Rehospitalization,

1 especially for those that are potentially avoidable, are a
2 good gauge of the care furnished by the facility, and we now
3 use this measure in evaluating the quality of SNFs, IRFs,
4 and home health agencies. Extending rehospitalization
5 measures to include a period after discharge holds providers
6 accountable for safe care transitions, and we have also
7 developed such measures for these settings.

8 Finally, the Commission has examined expanding
9 readmission policies across settings so that hospitals and
10 post-acute care providers have -- that the incentives are
11 aligned and focus on unnecessary rehospitalizations. Such
12 policies would hold PAC providers along with hospitals
13 jointly responsible for the care they furnish within their
14 own setting and for safe transitions between them.

15 And with this overview of the cross-sector work,
16 I'll begin our silo-specific analysis of the adequacy of
17 payments for the PAC settings, and I'm going to start with
18 SNFs.

19 First, I wanted to thank Lauren Metayer for her
20 work and help on this chapter. I'm going to start with an
21 overview of the industry and then present some information
22 related to the update and end with a summary of the Medicaid

1 trends that we are required to report.

2 Here's a quick overview of the industry. There
3 are just over 15,000 providers -- I mean just under 15,000
4 providers, and about 1.7 million or just about 5 percent of
5 beneficiaries use SNF services. Program spending in 2011
6 was almost \$32 billion, and Medicare makes up about 12
7 percent of days but 23 percent of revenues.

8 We'll be using our adequacy framework that at this
9 point you're quite familiar with. This work this year, the
10 Medicare cost reports for free-standing SNFs were not yet
11 available, and so in some places I've indicated what the
12 analysis found last year, and I'll describe our estimates of
13 2011 margins.

14 Access is stable and adequate for beneficiaries.
15 Supply has been steady, with a slight increase in providers
16 billing Medicare between 2010 and 2011. Three-quarters of
17 beneficiaries live in counties with at least five SNFs, and
18 the majority live in counties with ten or more. Covered
19 admissions and days were essentially unchanged between 2010
20 and 2011. Last year, I reported that there had been no
21 change in bed days available or occupancy rates, but this
22 year we didn't have updated information on that.

1 Turning to quality measures, we look at two
2 measures: risk-adjusted rates of discharge back to the
3 community and risk-adjusted rates of rehospitalization for
4 patients with five potentially avoidable conditions. Those
5 include CHF, respiratory infections, UTIs, sepsis, and
6 electrolyte imbalance. We see that there has been little
7 improvement in these rates since 2000.

8 Last year, the Commission recommended a
9 rehospitalization policy to hold SNFs accountable for
10 potentially avoidable readmissions. This policy would align
11 hospital and SNF incentives and hold both settings
12 responsible for unnecessary readmissions. You noted that
13 the measure should include a time period after discharge
14 from the SNF like the hospital measure does, and we worked
15 with the contractor to develop a risk-adjusted measure of
16 rehospitalizations for patients during 30 days after
17 discharge from the SNF.

18 In 2011, the combined rehospitalization for
19 beneficiaries while they are in the SNF or in the 30-day
20 period after discharge was 28 percent, with large variation
21 in both the within SNF and after discharge portions. Both
22 the level and the variation suggests considerable room for

1 improvement and potential savings for the program.

2 In terms of access to capital, there was more
3 lending in 2012 than there was in 2011, and HUD, the largest
4 lender to the sector, is expected to maintain its lending at
5 the same level next year. Non-HUD lending is also expected
6 to keep pace with 2012 levels, though there is some
7 uncertainty about federal and state policies. Medicare
8 continues to be the preferred payer in this sector, and
9 lenders and the industry use Medicare shares to gauge the
10 financial health of facilities.

11 As I mentioned before, the cost reports for free-
12 standing SNFs were not available for calculating margins for
13 2011. Therefore, we estimated margins using 2010 costs
14 trended forward, and we used 2011 claims to estimate
15 payments. We estimate the 2011 Medicare margin to be
16 between 22 and 24 percent, and this reflects the
17 overpayments that occurred within the new case-mix groups
18 were implemented. Even after the rates were lowered to put
19 them back in line with where they had been, margins for 2013
20 are estimated to be between 11 and 14 percent.

21 We didn't estimate margins by SNF group such as by
22 location, urban-rural, or by ownership group, but it's very

1 likely that the patterns that we've seen for many years
2 continue to hold true. There is a wide variation in
3 margins, and there's a large group of relatively efficient
4 providers with considerably lower costs per day, better
5 quality measures, and with high margins.

6 Last year, the Commission made a two-part update
7 recommendation. For the update year, you recommended that
8 the PPS be revised with no update, and then in the second
9 year, payments should be lowered by an initial 4 percent
10 with subsequent reductions made during a transition until
11 payments were more closely aligned with provider costs. For
12 those of you who were not here last year, I want to explain
13 the logic of this recommendation.

14 With SNF margins being so high for so long, the
15 Commission believed that Medicare payments needed to be
16 lowered. However, we knew that margins varied widely and
17 reflected systematic shortcomings in the PPS. Most
18 importantly, payments are driven by the amount of therapy
19 furnished, and payments are not targeted to patients with
20 high non-therapy ancillary costs, such as drugs.

21 In addition, the PPS does not have an outlier
22 policy. The Commission believed that before rebasing began,

1 the PPS needed to be revised to correct these biases. The
2 Commission first recommended revising the PPS back in 2008.
3 Without raising total spending, an alternative design would
4 shift payment within the industry. Payments would decrease
5 10 percent for SNFs that furnish a lot of intensive therapy
6 and would increase 17 to 18 percent for clinically complex
7 patients.

8 Based on a facility's mix of cases and their
9 therapy practices, payments would shift from free-standing
10 SNFs to hospital-based providers and from for-profit to
11 nonprofit SNFs, that is, from the highest-margin providers
12 to lower-margin providers.

13 The second part of the recommendation stated that
14 payments would be rebased beginning with the 4-percent
15 reduction. The Commission reviewed many pieces of evidence
16 that supported this reduction. First, aggregate Medicare
17 margins for SNFs have been above 10 percent since 2000.
18 Variation in Medicare margins is related to the amount of
19 therapy furnished, not differences in patient mix.

20 Differences in facility costs -- I think I went a
21 little -- sorry. Differences in facility costs are
22 unrelated to wage levels, their case mix, or beneficiary

1 characteristics. We've also found -- we've looked at
2 relatively efficient SNFs, and compared to other facilities,
3 we find that efficient have costs that are 10 percent lower,
4 community discharge rates that are 38 percent higher, and
5 rehospitalization rates that were 17 percent lower. And yet
6 they still had above average Medicare margins.

7 Another piece of evidence is that MA payments are
8 considerably lower than fee-for-service payments. When we
9 looked at five publicly traded chains, fee-for-service
10 payments averaged about 27 percent higher than MA payments.
11 It is unlikely that these large differences in payments are
12 explained by their mix of enrollees.

13 And, last, the industry has responded to the level
14 of payments in two ways. First, cost growth has outpaced
15 the market basket every year since 2001. And, second,
16 revenues grew even when steps were taken to lower their
17 payments.

18 The payment adequacy factors indicate that the SNF
19 landscape has not changed very much during the past year.
20 The Chairman proposes to maintain last year's recommendation
21 with a discussion of why these changes are still needed.

22 The language of last year's recommendation is on

1 this slide, and it would decrease spending relative to the
2 statutory updates, and we do not think it would affect
3 beneficiary access to care or provider willingness or
4 ability to care for beneficiaries.

5 As required by PPACA, we examined Medicaid trends
6 and spending, utilization, and financial performance for
7 nursing homes. About 15,000 facilities participated in
8 Medicaid, and that was a small decrease from 2011. Between
9 2008 and 2009, which is the most recent year of data, the
10 number of users increased slightly to 1.6 million. Spending
11 was just over \$50 billion in 2012, and that was a slight
12 decrease from 2011. Because we did not have cost reports,
13 we estimated non-Medicare and total margins for 2011. In
14 2011, the aggregate non-Medicare margin is estimated to be
15 between negative 1.2 and negative 3.2 percent, while the
16 total margin, which includes all sources of revenue across
17 all payers, was estimated to be between 3.8 and 5.5 percent.
18 And these are improvements over 2010.

19 The industry consistently posits that facilities
20 lose money on Medicaid and need the high payments from
21 Medicare to be viable. Using Medicare payments to subsidize
22 Medicaid payments is poor policy for a number of reasons.

1 Using Medicare days to direct subsidies to Medicaid ends up
2 helping exactly the facilities that need help the least. It
3 also doesn't discriminate between states with relatively
4 high and low payments, which we know vary two-fold. Even
5 after adjusting for wages, there's that much variation.

6 Medicare's high payments subsidize facilities even
7 in states with relatively high Medicaid rates. If Medicare
8 raises or maintains its high rates, it could encourage
9 states to freeze or lower their rates. And, finally,
10 payroll taxes redirect trust fund dollars to subsidize
11 payments from Medicaid and private payers. If the Congress
12 wishes to help nursing facilities with a high Medicaid mix,
13 then a separately financed and targeted program should be
14 established to do this.

15 And with that, I look forward to your discussion.
16 I'll just put up the Chairman's proposal right here.

17 MR. HACKBARTH: Okay. Thank you, Carol.

18 Herb, have you gone first?

19 MR. KUHN: No. And I would be happy to do so.
20 Thanks, Carol. Three quick questions.

21 One, on page 3, when you talked about 12 percent
22 of the days are about, what, 24 percent of the revenues, or

1 thereabout, if I recall right, maybe five years ago it was
2 like 10 percent, 20 percent. So has that gradually grown
3 over the last decade in terms of the number of days as well
4 as the percent of Medicare revenue?

5 DR. CARTER: I don't have that right in front of
6 me, and I think that's an easy fact to get.

7 MR. KUHN: And the second question, on the
8 rehospitalization issues, does the claims data permit us to
9 kind of understand the time of day when we're seeing those
10 rehospitalizations? That is, are they coming during the day
11 between 8:00 and 5:00? Or are they predominantly the
12 evenings or on the weekends? Do we have a sense of that at
13 all?

14 DR. CARTER: We don't have data on that.

15 MR. KUHN: Okay. And then, finally, I'm curious
16 about --

17 DR. CARTER: Well, I will say one interesting
18 thing anecdotally that I hear is that you do see more
19 admissions on Friday -- readmissions back to the hospital,
20 where staffing might start to get nervous and they know kind
21 of what the staffing levels might be on the weekend, and so
22 there is -- and that part, that is day of readmission where

1 you could probably --

2 MR. KUHN: Right, I have heard that as well and
3 was just curious if the claims data permitted to understand,
4 you know, to quantify that.

5 The final thing I was curious a little bit about
6 is the intensity of therapy services, and now with the
7 inpatient rehab facilities and the lockdown of the 60-
8 percent rule, so we're starting to see more therapy services
9 move to home health or to skilled nursing facilities, how
10 much of the increase in volume that SNFs are seeing are a
11 result of the movement from the IRFs to the SNFs? Do we
12 know?

13 DR. CARTER: There's a little pickup for SNFs, but
14 actually the bigger beneficiary, if you will, of that was --
15 I think more of those patients actually went to home health.
16 And that I think has pretty much stabilized by now.

17 MR. KUHN: Okay. Thank you.

18 MS. UCCELLO: So another observation status
19 question. I remember policymakers and articles and stuff
20 bringing up this three-day rule on observation status, but
21 nothing has changed. Is that correct? The observation
22 status still would not count toward the SNF eligibility?

1 DR. CARTER: That's right.

2 MS. UCCELLO: Thank you.

3 DR. DEAN: In terms of the payers, did you --
4 maybe I missed it. What is the proportion of Medicaid
5 payers?

6 DR. CARTER: About 60 percent.

7 DR. DEAN: 60 percent, okay. Thank you.

8 DR. COOMBS: Carol, I think you've actually given
9 this information before. What percentage are from home for
10 the SNFs?

11 DR. CARTER: Well, to qualify for the SNF benefit,
12 you have to have been hospitalized previously.

13 DR. COOMBS: So you have to come via the hospital.

14 DR. CARTER: Yes. You don't have to come
15 immediately, but I think most do.

16 DR. COOMBS: So if you go home for, like, a
17 certain amount of time, then you can bounce into the SNF?

18 DR. CARTER: Yes. And I --

19 DR. DEAN: 30 days.

20 DR. COOMBS: Is it 30?

21 DR. DEAN: 30 days.

22 DR. CARTER: It's 30 days, right. And I don't

1 think I actually looked at who went home first and then
2 quickly went to -- I haven't looked at that.

3 DR. COOMBS: Because indirectly that might be an
4 artifact -- it may be artificial, if they were in a
5 hospital, went home just for an intermediary period, and
6 then bounced into a SNF in terms of readmissions, you know,
7 if they were -- I don't know how you could capture that
8 information.

9 DR. CARTER: Well, when we're looking at
10 readmissions, we're, like, okay, so now you're in the SNF,
11 and are you going back to the hospital? So that's when the
12 readmission starts to count. So if somebody goes home and
13 then gets admitted to a SNF, we would only count that if the
14 person then went back to the hospital.

15 DR. COOMBS: Back to the hospital [off
16 microphone].

17 DR. COOMBS: Yeah.

18 DR. REDBERG: In looking at the SNFs, you gave us
19 some of the costs and the quality measures, and it looked
20 like there hadn't been a lot of change. Were there any
21 predictors of the ones that might have been at the upper end
22 of the quality, like rural versus urban or geographic

1 variations or anything else?

2 DR. CARTER: There is some geographic variation.
3 There's also variation by ownership, and there's a little
4 bit of variation by whether your hospital-based versus free-
5 standing. And I think -- we have a lot of information about
6 sort of the distribution and what those look like, and I can
7 get that to you.

8 DR. REDBERG: Thank you.

9 DR. HOADLEY: You mentioned or raised in the
10 meeting materials the new settlement on the improvement
11 standard and the fact that that may lead to some increased
12 utilization. Is there any sense in your mind of whether the
13 changes that you're recommending or the Commission has
14 recommended on the payment system would help in any way, or
15 is it just neutral to whatever might have gone on? Or is
16 that something you've even thought about?

17 DR. CARTER: To the extent that payments would
18 better reflect a patient's need for resources, then payments
19 in theory would be better matched, and they might get lower
20 in the sense that patients might not get therapy that they
21 currently get, even though they may not need that. And
22 particularly with the relaxation, if you will, of requiring

1 improvement, you might think patients would get less
2 therapy. So in that sense, I think there might be even more
3 interest to revise the PPS so that they're better matched to
4 the patients that are in -- the care needs of the patients
5 that are there.

6 DR. HOADLEY: I mean, obviously there's nothing
7 you can do empirically to talk about that, but maybe it's
8 worth sort of thinking through that argument, making a
9 little bit of that case as a further strengthening of...

10 DR. NAYLOR: The risk adjustment method for the
11 30-day readmission, I know you had comorbidities and
12 function. Was cognition a part of -- cognitive status a
13 part of the methodology?

14 DR. CARTER: You may know this, but the MDS, the
15 new MDS data has much better clinical information

16 DR. NAYLOR: Yeah.

17 DR. CARTER: So the comorbidity index that we use
18 has many elements of mental status and cognitive -- it
19 doesn't have like the CPS score, but it has things like five
20 or six different measures of mental illness in it now that
21 it didn't used to.

22 DR. NAYLOR: Okay.

1 MR. BUTLER: Two questions. I am ready, believe
2 it or not.

3 [Laughter.]

4 MR. HACKBARTH: Could have fooled us.

5 [Laughter.]

6 MR. BUTLER: Such an encouraging group. I'm going
7 to pause.

8 Okay. We worry a little bit about the hospice
9 care that also goes on in the skilled nursing and the
10 potential -- from an ownership standpoint, do you know of
11 any situations where you have common ownership over the
12 hospice and SNFs so that --

13 DR. CARTER: I would say yes, and I'm going to
14 turn to -- I think it's yes and a growing business element
15 of firms that own nursing homes and SNFs, I think hospice is
16 a growing arm of their business. Is that a fair statement?
17 Yeah.

18 MR. BUTLER: Okay. So the other question is, you
19 know, we're repeating the previous year's recommendations,
20 but I don't see us articulating the impact budgetarily,
21 maybe because we did last year, so it's not restated here.
22 But this was actually one of those things in the SGR letter

1 that had a big -- a \$23 billion number associated with it,
2 so I assume that, you know, as we look at this compared to -
3 - going back to the early-morning discussion on
4 sequestration and what -- there's no statement here that
5 reflects the savings that we can now, as Mike suggests,
6 direct toward SGR. What would the number be?

7 DR. MARK MILLER: I wouldn't want to say a number
8 offhand, but the process is coming in January and have our
9 usual buckets, and as part of that process in January, I
10 should be able to answer your questions.

11 MR. BUTLER: Okay.

12 MR. HACKBARTH: Although we're rewriting a
13 previous recommendation, we will still have a bucket --

14 MR. BUTLER: Well, some of the other materials
15 today have stated the impact. This one didn't, and I just -
16 - okay.

17 DR. MARK MILLER: It's probably more of an
18 oversight than anything else [off microphone].

19 MR. HACKBARTH: Mike, clarifying questions?

20 DR. CHERNEW: [Shaking head negatively.]

21 MR. HACKBARTH: Let me just ask one, Carol.

22 Would you put up slide 6? Well, it's six in the

1 SNF package. It's the quality measures graph. There we go.

2 As you know very well, I know nothing about the
3 quality measurement. But when I look at measures that
4 there's this little activity for this long a period of time,
5 as a layman I wonder whether it's a very sensitive or useful
6 measure.

7 So I guess a question about it is if this is the
8 average across all SNFs, if you look at individual SNFs do
9 you see movement, differences in level, differences in
10 trend, and it just happens that that all averages out to a
11 long, flat line? Or what?

12 DR. CARTER: As I mentioned to Rita, there is a
13 lot of variation. There's about a 60 percent variation in
14 these measures within the sector each year. But I don't
15 have in front of me to accurately state what you're looking
16 for, which is sort of within -- over time, what's going on?
17 Do you see a lot of bouncing around? And I don't know that.

18 MR. HACKBARTH: I can't think of any other
19 measures that we've looked at that have this pattern, this
20 utter lack of movement over a long period of time. And
21 that's what prompts the question.

22 Herb, round two?

1 MR. KUHN: I think rerunning the recommendation
2 from last year makes sense and I support doing that.

3 MS. UCCELLO: Me, too.

4 DR. NERENZ: [off microphone] I support
5 [inaudible].

6 DR. COOMBS: I support the recommendation.

7 DR. REDBERG: I support the recommendation.

8 MR. ARMSTRONG: Me, too.

9 DR. HOADLEY: Likewise.

10 DR. NAYLOR: Just stay there, yes.

11 DR. HALL: I'm good.

12 MR. GEORGE MILLER: I'm good.

13 DR. SAMITT: It's good to me, too.

14 DR. NAYLOR: I support the recommendation.

15 DR. BAICKER: Ditto.

16 MR. BUTLER: I'm not ready.

17 [Laughter.]

18 MR. BUTLER: I support the recommendation.

19 [Simultaneous discussion off microphone.]

20 MR. HACKBARTH: Thank you very much.

21 Next up is home health.

22 Actually -- oh, never mind. I'll do it next time.

1 Evan, go ahead and proceed with home health.

2 MR. CHRISTMAN: Good afternoon. Now we'll go
3 through the framework as it relates to home health.

4 As a reminder, here is our framework. It is the
5 same one for the other sectors you had in earlier
6 presentations.

7 Before I begin, I want to remind you how the home
8 health benefit works. To qualify for the service,
9 beneficiaries need to be homebound and have a need for
10 therapy or nursing. Home health plays an important role in
11 serving beneficiaries who have trouble leaving home to
12 receive care. A common use of the service is for
13 beneficiaries returning to home after hospitalization,
14 though a prior hospitalization is not required in order to
15 receive the benefit.

16 Medicare pays for home health under a PPS. The
17 PPS makes case-mix-adjusted payments for each 60 days of
18 service.

19 The Commission has noted several challenges with
20 the home health benefit. First, the benefit is broadly
21 defined and permits beneficiaries to remain on service for
22 long periods of time.

1 The benefit has an unfortunate history of fraud
2 and abuse, and the paper notes many areas with aberrant
3 patterns of utilization. In addition, providers in this
4 sector also have a history of tailoring services to reflect
5 the financial incentives under Medicare payment, and I'll
6 say more about that in a few slides.

7 Medicare spent about \$18 billion on home health
8 services in 2011. The program provided about 6.9 million
9 episodes to 3.4 million beneficiaries.

10 We begin with supply. As in previous years, the
11 supply of providers and the access to home health continues
12 to increase. Ninety-nine percent of beneficiaries live in
13 an area served by one home health agency; 80 percent live in
14 an area served by five or more. While there are some areas
15 that lack home health agencies, they are relatively few in
16 number.

17 Turning from access to supply, the number of
18 agencies was over 12,000 by the end of 2011. This was a net
19 increase of 512 agencies in 2011, with 730 agencies entering
20 the program and 218 leaving.

21 Next we will look at volume. The volume trends in
22 2011 are a departure from what we have reported in prior

1 years. For the first time we see little significant growth
2 in the number of users or episodes, as shown in the right-
3 most column in this chart. However, this break in growth
4 comes after several years of rapid increases. For example,
5 the number of users increased by over a third in 2002
6 through 2010 and the number of episodes increased by 69
7 percent.

8 We are still reviewing the factors that could
9 account for this slowdown in growth in 2011, but it is
10 notable in this year that CMS put into place a new
11 requirement for physicians to conduct a face-to-face
12 examination of beneficiaries for whom they order home
13 health. It is possible that the additional scrutiny
14 required by this examination led to fewer referrals.

15 Home health spending declined by 5 percent in
16 2011. This decline was mostly due to a 5-percent reduction
17 in the base rate CMS implemented in this year. Similar to
18 the changes in volume, this decline comes after many years
19 of growth. Aggregate spending on home health roughly
20 doubled between 2002 and 2010.

21 The home health PPS currently uses per visit
22 payment thresholds that increase episode payments when

1 additional therapy visits are provided. The Commission
2 observed two problems with this arrangement.

3 First, the use of the number of visits as a
4 payment factor permitted agencies to target their care
5 protocols to the number of visits that were most profitable.
6 In years when CMS has set or revised the therapy payment
7 thresholds to redistribute payments, agencies have increased
8 the volume of episodes with higher payments after the
9 revisions and decreased volume for the therapy episodes with
10 lower payments after the revisions. These timely shifts in
11 volume suggested that financial incentives may be overriding
12 patient needs when therapy plans of care were set.

13 Second, therapy episodes increased faster than
14 other services in home health. We found that agencies which
15 provided more therapy episodes had higher margins. These
16 findings suggested that therapy was overvalued relative to
17 other services in the PPS.

18 Based on these findings, we recommended that CMS
19 eliminate therapy thresholds and set payment for these
20 services based on patient needs. This budget-neutral change
21 would have been redistributive and would increase payments
22 for low-margin providers and reduce them for higher-margin

1 providers.

2 CMS recognized the vulnerabilities of the system
3 that we cited and made two changes, but it has left the
4 system of payment thresholds in place.

5 CMS has tightened the review requirements for
6 episodes with 14 or more visits, and the intent of this
7 review was to ensure that patient needs were being
8 considered before additional visits were provided. This
9 requirement appears to have had some effect as the volume of
10 episodes subject to this requirement declined in 2011.

11 However, these additional review requirements did
12 not apply to 70 percent of therapy episodes. The volume of
13 these episodes continued to increase. It is striking that
14 episodes not subject to the new review requirement continued
15 to grow while those that were declined and suggests that
16 further safeguards might be beneficial.

17 Perhaps most importantly the need for an
18 additional review requirement could be eliminated if CMS
19 implemented our recommendation to end the use of the
20 thresholds and use patient characteristics to set payment
21 for therapy services.

22 A second change in 2012 recognized MedPAC's

1 concern that therapy was overpaid relative to other
2 services. CMS raised payments for non-therapy services and
3 reduced them for therapy services through adjustments to the
4 case-mix index. This would address at least some of our
5 concern that therapy services are overvalued relative to
6 non-therapy services.

7 However, even with these two changes, the visit-
8 based payment thresholds remain in place, and payment for an
9 episode increase as additional therapy visits are provided.

10 Our next indicator is quality. This table shows
11 the risk-adjusted rates of functional improvement among
12 those patients not hospitalized at the end of their home
13 health episodes. Across the two years, you can see that the
14 rates of functional improvement increased slightly on most
15 measures, implying a modest improvement in quality.

16 A limitation of these measures is that they do not
17 measure quality for beneficiaries that were hospitalized.
18 These cases may have outcomes that are different from these
19 shown on the table.

20 Next we look at capital. It is worth noting that
21 home health agencies, even publicly traded ones, are less
22 capital intensive than other health care providers; also,

1 few are part of publicly traded companies.

2 Financial analysts have concluded that the
3 publicly traded agencies have adequate access to capital,
4 though because of the payment reductions in the PPACA and
5 several federal investigations into industry billing
6 practices, the terms are not as favorable as prior years.

7 For agencies not part of publicly traded
8 companies, the continuing entry of new providers indicates
9 that smaller entities are able to get the capital they need
10 to expand. As I mentioned earlier, over 700 new agencies
11 entered Medicare in 2011.

12 Next, we turn our attention to margins for 2011.

13 You can see that the overall margin for free-
14 standing providers is 14.8 percent. However, there is some
15 variation in the margins. The agency at the 25th percentile
16 had a margin of negative 0.3 percent, while the agency at
17 the 75th percentile had a margin of 23 percent. Margins for
18 providers that primarily serve urban patients were 14.8
19 percent and 15.3 percent for agencies that primarily serve
20 rural patients.

21 We also examined the distribution of margins for
22 rural providers, and they exhibited the same distributional

1 pattern as urban providers. From these facts we can
2 conclude that the aggregate level and distribution of
3 margins is similar for urban and rural providers.

4 For-profit margins equal 15.7 percent; nonprofits'
5 were 12.2. These margin estimates are our starting point
6 for estimating 2013 margins. These numbers highlight two
7 concerns that the Commission has had for many years: that
8 home health margins have been excessive and the wide
9 variation in margins.

10 This year we are also examining the performance of
11 relatively efficient home health agencies compared to other
12 agencies.

13 We identified relatively efficient home health
14 agencies by examining cost and quality for a three-year
15 period. Agencies were classified as relatively efficient if
16 they were consistently in the top third of at least one of
17 these measures in each of the three years and not in the
18 bottom third on the other measure. About 14 percent of the
19 agencies in our sample met this criteria.

20 Relatively efficient providers had a cost per
21 visit that was 15 percent lower than other agencies and
22 Medicare margins that were 28 percent higher. Relatively

1 efficient providers were typically larger in size, providing
2 about 30 percent more episodes in a year. They had lower
3 hospitalization rates, and they provided about the same mix
4 of nursing, therapy, and aide services to their patients,
5 and they served similar numbers of dual-eligible patients,
6 and their beneficiaries were about the same average age.

7 These results suggests that relatively efficient
8 providers achieve better performance through lower costs and
9 are typically able to provide better quality than other
10 providers. Some of these lower costs may be attributable to
11 the typical larger size of relatively efficient home health
12 agencies.

13 Here is the margin for 2013. We estimate margins
14 of 11.8 percent in 2013. This is a result of several
15 payment and cost changes.

16 PPACA reduced the market basket by 1 percent in
17 2012 and 2013. In addition, CMS reduced payments in 2012
18 and 2013 for changes in coding. Also, there is a 3-percent
19 add-on in effect for rural areas in 2010 through 2015. We
20 assumed cost growth of half a percent annually in 2012 and
21 2013, consistent with historical rates of growth.

22 Here is a summary of our indicators.

1 Beneficiaries have good access to care in most areas. The
2 number of agencies continues to increase, reaching over
3 12,000 agencies in 2011. The number of episodes and rate of
4 use are steady after several years of rapid increases.
5 Quality shows improvement on most measures, access to
6 capital is adequate, and margins are projected to equal 11.8
7 percent in 2013.

8 I would note that these are average margins, and
9 our review of the quality and financial performance for
10 relatively efficient providers suggests that better-
11 performing agencies can achieve even better outcomes --
12 excuse me, even better profits while holding quality
13 constant or doing better than the average provider. I would
14 note that these results overall are similar to what we have
15 reported in prior years.

16 Since our indicators are largely unchanged from
17 previous years, the Chairman has proposed that next year's
18 report reprint the recommendation approved for the March
19 2011 report. The Commissioners may recall that current law
20 includes a softer form of rebasing. Our recommendation
21 differs from current law in that it phases in the lower
22 rates faster, in two years instead of four; in addition, our

1 recommendation eliminates the annual payment update during
2 rebasing. Current law includes the annual update as an
3 offset to the rebasing reductions. Our recommendation would
4 decrease spending in 2014, and we would expect beneficiary
5 access to remain adequate though there may be some
6 contraction in supply.

7 This completes my presentation.

8 MR. HACKBARTH: Okay. Thank you, Evan.

9 Could I ask a question about Slide 7? You noted
10 that after a number of years of rapid growth, that pattern
11 seems to have changed, at least temporarily. You speculated
12 that perhaps one of the reasons might be the physician
13 certification requirement.

14 As I recall, our work on geographic variation
15 showed that home health and DME and a few other services
16 were huge contributors to geographic variation in total cost
17 per beneficiary. So these dollars are not evenly spread
18 across the map. Some areas have dramatically higher levels
19 of home health spending than other areas. At least some of
20 those very high areas have also been subject to intense
21 scrutiny recently for fraud and abuse, et cetera. Do you
22 think potentially that is also having an effect? Is there

1 any way to look at the data to see whether the biggest
2 change in the trend is in some of those high-cost areas?

3 MR. CHRISTMAN: You know, every year we look at
4 the top 25 counties in terms of utilization, and there has
5 been a drop in those areas. They're still very high, and so
6 it may be that some of that is due to a decline in
7 utilization in the high-use areas.

8 The point I guess I would make is that, you know,
9 laying aside the fraud and abuse, on an annual basis we were
10 having years where we were seeing 200,000, 300,000 new
11 episodes a year. So to go from that to this year where it
12 was approximately 10,000 new episodes, certainly fraud and
13 abuse may be a part of that. But the magnitude of the drop
14 suggested that there might be some broader factors, too.

15 MR. HACKBARTH: Okay. And then one other
16 question, this one about Slide 10, the quality measures.
17 Remind me, you know, looking just at these, it seems like
18 there might be a substantial element of subjective grading
19 in these measures, that home health agencies are in a sense
20 evaluating their own performance and saying, you know, my
21 patients are doing better at bathing or walking. And if
22 there are incentives for lenient grading, you could get

1 results that really aren't particularly meaningful.

2 Remind me, are there instruments, is there some
3 discipline to this grading system that at least alleviates
4 that concern a little bit?

5 MR. CHRISTMAN: Well, I think I would just note
6 that the -- I would note two things. I mean, this uses the
7 OASIS instrument, so there's a standardized scale that
8 they're being assessed at at admission and discharge. So
9 part of the answer to your question is that there's a set of
10 rules they're supposed to follow when they grade them, but,
11 still, it's the agency, yes, evaluating their own work.

12 The other thing I would note, I'm not sure this
13 helps answer your question, but the trend in these measures
14 has been relatively stable. They've all increased by one to
15 two percentage points a year, and, you know, I'm not sure
16 that you can see both sides of that, but we do at least see
17 some consistency on what agencies are reporting. But I
18 don't know that there's any secondary data that we could go
19 to to sort of look behind the functional measures.

20 DR. NAYLOR: Thanks, Evan. I wanted to ask a
21 question about disentangling post-acute, which is
22 immediately following hospitalization, from the rapidly

1 growing segment of home health, which is the chronic care,
2 not preceded by hospital. And I'm wondering, as you look at
3 the efficient hospital or efficient home health slide, if
4 you can help us to understand. Can you disentangle those
5 two groups?

6 MR. CHRISTMAN: We can. I haven't done that
7 particular slice of this piece of the efficient provider
8 looking at how many people are preceded by -- what share of
9 their episodes are preceded by a hospital stay, but we can
10 look at that.

11 DR. NAYLOR: And one in particular, you noted in
12 the report that the efficient home health has a decreased
13 number of visits, 0.8 per episode, and I think it will be
14 really important to know what is the visit pattern per
15 episode when it's post-acute versus chronic, because they're
16 entirely different services.

17 MR. CHRISTMAN: Right, and I guess I would just --
18 you know, I'm not sure this is -- my intuition would be that
19 the mix won't vary, I mean, because the mix of nursing,
20 aide, and therapy did not vary between the relatively
21 efficient and all other agencies. And that would lead me to
22 guess that the mix of the prior hospital episodes won't be

1 that different either. But we can look at that.

2 DR. NAYLOR: So then can you speculate on why
3 you're seeing one segment grow rather dramatically and
4 another part of home health decrease?

5 MR. CHRISTMAN: I think that there's two pieces we
6 have to look at to really get that answer right, and there's
7 two things that could be driving it. One is, you know, how
8 many people are getting admitted to home health directly
9 with no prior hospitalization and staying on for however
10 long they stay on. That will be one thing that drives
11 growth in the non-post-acute 60-day episodes.

12 The second thing that can drive it is, you know,
13 we always give those numbers in terms of how many payment
14 episodes are preceded by a hospitalization, and so what can
15 happen is a patient can be admitted after a hospitalization
16 and then they can stay on for a number of episodes. So
17 their first episode will be look like a PAC episode, but if
18 they have two or three episodes after that, then those will
19 look like non-PAC episodes because they were not preceded by
20 a hospitalization. That's sort of like what's your original
21 source of the admission. And, you know, as PAC patients,
22 people who are originally admitted from the hospital stay

1 longer, they'll have non-PAC episodes. So sort of tangling
2 -- those are sort of the two pieces to kind of understand
3 what's driving the increase in the non-PAC episodes.

4 MR. HACKBARTH: Let me ask this. You've made this
5 point a couple times today, Mary, the difference between the
6 post-acute patient and the patient admitted from the
7 community, say somebody with a chronic illness, and it makes
8 great sense to me. Yet in this payment system we're lumping
9 them together. I almost wonder whether we ought to be
10 thinking, if not about different payment systems, but, you
11 know, different conversion factors or some difference in the
12 payment mechanism to reflect, you know, fundamental
13 differences in the two categories.

14 DR. NAYLOR: I will save this until later or
15 answer it now, but I think this is really fundamentally
16 important. I mean, we're talking about trying to build a
17 care system; the bundled payment is thinking about hospital
18 admission, some of the models, to post-acute. The whole
19 notion of improving transitions of people during a very high
20 risk time is figuring out how to better connect these two.
21 And yet when we look at the data that Evan and others have
22 provided, it shows really -- was it a 117-percent increase

1 in the use of home health as a community chronic care
2 service rather than in connecting these two?

3 So I do think it's important for us to know how
4 these services are being used, by whom, for what outcomes
5 you're seeing post-acute in the real traditional sense of
6 hospital to home versus those that are being picked up in
7 the community.

8 MR. HACKBARTH: Okay. Interesting point.

9 DR. HALL: It came up several times that with
10 bundling and probably with accountable care organizations
11 that hospitals are going to take a much closer look at home
12 health agencies because they're incentivized to keep people
13 out of the hospital. My experience has been with home
14 health that up to now they have tried to protect themselves
15 against patients that had very high care needs so that they
16 had the right to say this patient is ineligible for home
17 health care services because they have too many problems.

18 Is there any speculation that this might really
19 change the whole dynamics?

20 MR. CHRISTMAN: Well, I would say that there's
21 definitely a lot of discussion about home health can partner
22 with hospitals in reducing readmissions. I think in terms

1 of, you know, will it change -- are there patients that
2 they're not taking now that, you know, they'll decide to
3 take, I really haven't heard too much discussion about that.
4 You know, we hear a variety of different concerns. I think
5 the greater concern we hear, frankly, is in areas that are
6 saturated there's a lot of competition for who's going to
7 get certain patients and concerns that that sometimes
8 results in, you know, business arrangements that aren't
9 appropriate. But, you know, I think there's no requirement
10 that a post-acute provider ever take a patient. I think
11 that, you know, that's a general concern sometimes that I
12 hear about, you know, PAC in general, whether they're trying
13 to place people in SNFs or home health, and if you
14 experience is it occurs in home health, then certainly it's
15 possible.

16 MR. GEORGE MILLER: Excellent report. I want to
17 focus in on some of the material in the paper concerning the
18 areas where we have more of a challenge with mischief or
19 aberrant behavior.

20 Has the staff looked at those five states with the
21 usual suspects that we have very high potential
22 overutilization and see what would be the impact if we were

1 able to eliminate those from the lexicon, from the members,
2 and would the rest of the -- I've heard numbers like maybe
3 half of the aberrant behavior could be in just those five
4 states, and if we eliminate that, what would the rest of the
5 country look like?

6 MR. CHRISTMAN: You know, we haven't -- I don't
7 think we've quite looked at it that way. I mean, I think we
8 definitely do see that there are, you know, certain areas
9 and really within the states it's usually a few counties,
10 with some exception, you know, that we see high utilization.
11 I mean, I guess it's sort of a question of what you say when
12 you say we eliminate the aberrant utilization. I think
13 that's always -- it's easy for us to identify an outlier.
14 It's a little bit harder to say, you know, how much lower
15 should utilization be in Miami or Hidalgo. You know, we
16 could talk about what it would be if it were the national
17 average, but, you know, there's a significant chunk that
18 would probably get pulled out if you were able to pull
19 things down.

20 MR. GEORGE MILLER: I'll follow up. That's the
21 question I'm asking. Let's say if those five states were at
22 the median across the United States, what would that do for

1 spending? And would the focus be -- you know, we've got a
2 lot of extra spending particularly in those five states, and
3 I've heard numbers it's about half of -- and you've got a
4 lot of growth in those five states. So if we did something
5 like put a moratorium or froze payments, would the rest of
6 the country be normal, what we would think?

7 DR. MARK MILLER: This is the way I would try to
8 answer this. There's a very easy and a very hard part of
9 your question. If you said to us, okay, let's assume
10 utilization rates in, you know, all areas of the country at
11 least were brought down to, let's just say, the 75th
12 percentile, you know, we can do a calculation and tell you
13 what impact that would have on spending if that was a true
14 expression of what happened and what the rest of the country
15 would look like.

16 I think it's the second part of your question, so
17 if I had a moratorium or so if I did pump a bunch of money
18 into program integrity or so -- you know, however you finish
19 that sentence, would that get me there, that's what I think
20 Evan is more concerned about answering. We can do the
21 calculation. It's useful to say perhaps to the country this
22 represents something of an opportunity. It's always that

1 next question of, like, okay, so how do I get it? Because
2 some of this, even by its very nature, is avoiding being
3 caught. So the truly fraudulent behavior -- sorry. I put
4 that eloquently as usual.

5 [Laughter.]

6 DR. MARK MILLER: And some of it is designed not
7 to be detected, and then some of it is more inappropriate
8 utilization. And I think Evan's point is he can't -- and I
9 think it might even be hard for this group to say this is
10 inappropriate utilization, this isn't, and that's kind of
11 the problem with the whole area.

12 MR. GEORGE MILLER: But you do have it identified
13 in five states.

14 DR. MARK MILLER: But the exercise, you know, that
15 you say, the first part of your question, that's not hard to
16 do, and we can certainly put it in and say, you know, pay
17 attention, folks, there's an opportunity here. It's just
18 harder to say how do you put your arms around it.

19 MR. GEORGE MILLER: Okay.

20 DR. SAMITT: So I guess my question is in the same
21 vein. Nice job, Evan. I guess I -- this is the slide I'm
22 interested in, you know, is there promise kind of in the

1 world of bundled payments and accountability that we'll be
2 able to address this. So is there any evidence when you
3 look at the most efficient agencies that they are the
4 organizations that are pursuing ACOs, that they are Medicare
5 Advantage plans, that it's not just payer accountability in
6 search for fraud but it's provider accountability that is
7 really focusing on opportunities for efficiency. I don't
8 know if you've broken it down that way.

9 MR. CHRISTMAN: I haven't quite looked at it that
10 way. I mean, I think that -- I definitely am sort of
11 watching this space to see what agencies do. Part of the
12 challenge with home health -- I guess it's true of all
13 providers, but they vary substantially in their abilities.
14 The Visiting Nurse Service of New York can probably do any
15 care model you could possibly build. They're the largest
16 home health agency in the country. They operate an MA plan.
17 They have all kinds of different programs that would, I
18 think, be similar to many of the goals that the Commission
19 has for reform.

20 Then there's a lot of other much smaller agencies
21 that function like a more traditional home health agency,
22 and some of them may be interested in new models of care and

1 others may be focused on their current model. So I would
2 expect there would be sort of a big range in their
3 preparedness to kind of take the next steps you're talking
4 about.

5 MR. HACKBARTH: I was struck, Craig, by your
6 comment at the last meeting when we talked about having a
7 pay-for-performance component on home health on
8 readmissions. As I recall, what you said -- and correct me
9 if I missed your point -- was that maybe the best way to get
10 to that destination is not adding a payment adjustment, but
11 hospitals, for example, faced with their own incentive to
12 reduce readmissions will start to be selective in where they
13 refer patients for home health care, and the agencies that
14 are really good at helping avoid readmissions will get more
15 business and that will be a powerful incentive for them to
16 focus on that.

17 And I think that's potentially a very powerful
18 point, and I wonder whether, when we try to look at what's
19 an efficient home health agency, whether it would be
20 interesting just to look at some case studies of different
21 markets, markets that are more developed in that sense, and
22 see if the home health agencies in those markets perform

1 differently, have different characteristics, from those
2 where you don't have a lot of ACO activity or really robust
3 Medicare Advantage plans. It wouldn't be an analytic study
4 where you'd say, here's the statistical relationship, but it
5 might be an interesting way of looking at the Samitt
6 hypothesis.

7 DR. SAMITT: Well, I mean, I think the reality is,
8 is living in the ACO space today, many vendors in our
9 community and many potential partners are coming to us
10 because they're afraid about our selecting different
11 partners, whether it's SNF or home nursing or what have you,
12 and we would like to align with those that are more focused
13 on better care at a lower cost. So you can only imagine
14 that the incentive sitting on the provider side through the
15 form of ACO or other potential penalties or benefits would
16 very much drive the transformation further downstream. So I
17 would welcome sort of an evaluation of that hypothesis
18 because I would imagine it could be true.

19 MR. KUHN: Glenn, if I could just -- I, too, would
20 find that interesting, but, I guess, isn't -- maybe Evan or
21 Mark or others can answer this -- it's not permissible under
22 current law to do that kind of steering of patients for home

1 health or SNF, is that correct, if they're in the fee-for-
2 service program?

3 MR. CHRISTMAN: Yeah. There is a provision --
4 it's loosely referred to as the Freedom of Choice Provision
5 -- that beneficiaries are supposed to be notified that the
6 following agencies are in their area. But I think that
7 Bill's comments indicate how complicated this can be in the
8 sense that there could be ten agencies in an area, but
9 you'll get to the peculiarities of what agencies will differ
10 in their ability to take a given patient because of their
11 clinical sophistication or just their capacity, and so how
12 much choice folks experience in practice, I think, is
13 something that we kind of wrestle with.

14 MR. HACKBARTH: I had lost sight of that, Herb, so
15 thanks for that. But I would imagine that most Medicare
16 beneficiaries, when they get their list of the five or ten
17 or whatever the number of agencies is, they say, well, which
18 one should I go to, and whatever they're advised to use by
19 the hospital discharge planner is the one they end up using.

20 DR. REDBERG: Do you think any of them use Home
21 Health Compare?

22 MR. CHRISTMAN: It's available. I don't get the

1 sense that it -- we haven't talked about this too much, but
2 when I talk with folks about the factors that end up getting
3 weighed, it doesn't come up very often that consumers are
4 taking a hard -- I guess the aside I would say on Home
5 Health Compare is when they were building those measures,
6 they convened a panel of consumers to say, you know, do
7 these measures make sense to you, and the report explaining
8 how those focus panels went said that a lot of the
9 presentation was taken up by the presenters explaining what
10 home health was. So I think that that's sort of the
11 challenge, is people -- I think it's hard for people, unless
12 you're like me and you spend a lot of time with it, but for
13 consumers, they don't really understand what the parameters
14 of the service are until they actually start to use it. So
15 I think that that's a challenge when they're looking at that
16 list of providers.

17 DR. MARK MILLER: I'm sorry. Just beyond the
18 hypothesis and the analysis, I mean, maybe the policy -- and
19 this is thinking off the top of my head -- the policy we
20 start to think about is if there is some alignment, and we
21 define how that's aligned, I'm in an ACO, then you are
22 relieved from certain pressures in fee-for-service. So

1 there is a readmission penalty. But if you go into an ACO,
2 no readmission penalty, that type of thing. And so you've
3 got a push-pull going both in fee-for-service and ACO. And
4 I'm making all this up on the spot, so I've have to think it
5 through a lot more with Evan, but that kind of thought. And
6 maybe in addition to your thought, we could come back with
7 something like that.

8 DR. NERENZ: Yeah, a couple quick questions about
9 the OASIS instrument that you mentioned. I think you said
10 it was required at the beginning and end of each episode, is
11 that correct? And is that true without exception at all,
12 any episode, any kind --

13 MR. CHRISTMAN: In Medicare, yes.

14 DR. NERENZ: In Medicare.

15 MR. CHRISTMAN: Now, the wrinkle is, and we talked
16 a little about this last month, is that it's -- the agency
17 is required to complete it, but they're only required to
18 send -- of all the patients they serve, if they send one of
19 those to Medicare, report that data, then they have met all
20 their reporting obligations. So the data is collected.
21 Whether we always have complete information for the national
22 statistics we support, but what we report is a second issue.

1 DR. NERENZ: Okay. I'm mainly just interested in
2 the requirement to collect. Now, I was in a meeting
3 recently, somebody made reference to a 30-some-page intake
4 form. Is that plausibly referring to OASIS --

5 MR. CHRISTMAN: It quite possibly is, yes.

6 DR. NERENZ: Thank you.

7 MR. BUTLER: So on this one, and you have more
8 data in the chapter on the efficient agencies. Now, this is
9 sort of different from the other sector. You've got 12,000.
10 If you look at, like, inpatient rehab or LTCHs or dialysis,
11 there's consolidation and some fairly big for-profit
12 companies, and there's very little of -- this is kind of a
13 cottage business. So when I look at this, the only thing I
14 see is the -- I see that it can be done, but the only
15 characteristic really is the size, 29 percent bigger, which
16 isn't really big.

17 So I'd like to learn a little bit more. Are these
18 located in certain geographic areas? Do they -- what else
19 do we know about these high performers besides that they're
20 slightly bigger, would be helpful.

21 MR. KUHN: Yeah. I was reading one of the letters
22 that the Commission received, and this one was from the

1 Partnership for Quality Home Health Care, and that's a
2 little bit some of the data that George was talking about.
3 So they mention these five States, California, Texas,
4 Florida, Illinois, and Ohio, and there were three kind of
5 interesting facts in here about those five States. One,
6 that more than half of all home health agencies are located
7 in just those five States; that about 83 percent of the new
8 providers in this space are in those five States; and that
9 basically nearly half of all Medicare home health payments
10 are in those five States.

11 So I guess I was interested in your response to
12 George's question, Mark, and I think that was real helpful
13 for me. But I guess the question is, as we look at the
14 overall margins across the country, do we see some
15 differentiation in margins? Do we see them -- are they
16 higher in these five States versus others, because I think
17 about -- Tom has raised it many, many times here, and he
18 talks about South Dakota and the margins just aren't there
19 in that State. So, obviously, we're looking at this margin
20 rate that we're projecting of 11.8 percent. Is that pretty
21 standardized across the country, or do we see higher margins
22 in these States and then lower margins in States like where

1 Tom's from?

2 MR. CHRISTMAN: It's been a while since I've
3 looked at the State by State level. There is some variation
4 among the States, and I'm reaching deep into my memory banks
5 here, but generally, they're almost -- even the low ones at
6 the State level are generally still double-digits, cracking
7 ten percent. You know, when you look at the variation
8 across the States, you have to keep -- there's two pieces we
9 haven't really ever disentangled that can drive some of
10 that, and whether there are some inadequacies and problems
11 in what the wage index is doing, because that's going to be
12 a big difference among those areas. And the other thing is
13 that we have observed that agencies with higher therapy
14 delivery, that deliver more therapy episodes, generally do
15 better. So you have to think about the differences and sort
16 of those factors and how they explain some of the spread
17 that you see.

18 [Off microphone discussion.]

19 DR. DEAN: I was interested in the written
20 material, the issue of the improvement standard and the fact
21 that is that really not applicable anymore? I mean, it
22 certainly has been something we've relied on a lot, not so

1 much for home health, because we don't have any home health
2 --

3 [Laughter.]

4 DR. DEAN: -- but in other areas. Is that truly
5 not going to be something that's usable now?

6 MR. CHRISTMAN: That's the court settlement, that
7 the standard effectively is going away.

8 DR. DEAN: Because that's going to complicate
9 things significantly in terms of determining where an end
10 point for some of this stuff is, but --

11 MR. CHRISTMAN: Yeah. There's still a lot to be --
12 - you know, we're kind of in this -- as I understand it,
13 we're in a current kind of limbo where they've said --
14 they're stopped enforcing the improvement standard, but they
15 haven't put out refined guidance that kind of gives people
16 an idea of whether there are any other secondary changes
17 that go along with this. In the future, what's going to
18 apply generally for home health is whether you are homebound
19 and whether you have a skilled need. Those are sort of the
20 two first primary checkpoints you have to clear and the
21 improvement standard is gone. So, certainly, that could
22 open the door for people to stay longer or for people who

1 otherwise wouldn't have qualified to get in.

2 DR. DEAN: Okay. Another question, I guess I
3 never really have understood rebasing, but if that were to
4 take place, the problem with the facilities that the agency
5 that I'm familiar with is low volume and lots of travel and
6 that makes them financially non-viable. And just an aside,
7 I don't think there's been a new home health agency in South
8 Dakota in probably five years. I could be wrong, but if it
9 is, it's only one or two. Does rebasing address any of
10 those issues?

11 MR. CHRISTMAN: I mean, no.

12 DR. DEAN: Okay.

13 MR. CHRISTMAN: But I guess another way to think
14 about it is if there are areas that truly have access
15 problems, Medicare already has a rural add-on, and --

16 DR. DEAN: But even with that, we have lost
17 agencies.

18 MR. CHRISTMAN: And I guess the next point I was
19 going to go to, Tom, is that Medicare, three percent rural
20 add-on, it's a couple hundred million dollars a year. But
21 because it's targeted at the episode level, rural areas that
22 have more episodes get more of an add-on payment. Seventy

1 percent of the add-on dollars flow to rural counties with
2 utilization above the national average.

3 DR. DEAN: Yeah. Okay.

4 MR. CHRISTMAN: So Medicare -- it set aside money
5 to address the type of situations you're talking about, and
6 it may be thin gruel for the real problems you see in your
7 area, but I'm afraid that I kind of see the other side of
8 this, that there's a lot going to areas that probably don't
9 need it.

10 DR. DEAN: Well, and I would completely agree, I
11 mean, and I think it's clear as we dig through a lot of this
12 stuff that the rural-urban cut is not the useful cut. Well,
13 I mean, we could have a long discussion about that. But
14 that clearly -- I mean, it's a distinction we've relied on a
15 lot, but it clearly doesn't tell us what we need to know.

16 MR. HACKBARTH: This is another good illustration
17 of the point that we've now discussed several times recently
18 about the importance of good targeting and just across-the-
19 board rural add-ons, especially, paid the way. Evan
20 describes it as an add-on to each episode, may not be very
21 effective targeting for the unusual situations that you're
22 most concerned about, Tom.

1 MR. KUHN: If I could just follow on -- I'm sorry,
2 Tom, to get on your time here, but the LUPA adjustment, does
3 that play much in terms of areas that Tom is talking about?
4 And if it does, when is the last time that particular
5 adjustment was really looked at in detail to make sure that
6 it's properly targeted, as well?

7 DR. DEAN: And then you could tell me what it is.
8 I didn't understand it.

9 MR. HACKBARTH: Yeah. That's the low utilization
10 adjustment. So if -- it's at five visits?

11 MR. CHRISTMAN: [Off microphone.] Fewer than
12 five.

13 MR. HACKBARTH: Fewer than five visits, then
14 Medicare doesn't pay it on an episode basis but on a per
15 visit basis.

16 MR. CHRISTMAN: Overall, they are about ten to 15
17 percent of episodes, but because the payments are so low,
18 they're, like, one percent of the money. I would be
19 surprised if that is a huge factor in the differences, or
20 the issues that rural areas experience. Certainly, they may
21 experience losses on those episodes because they are small
22 and the payments are very low, but if you fixed that, you

1 would probably still have -- 99 percent of the money in the
2 system is for the regular episodes, not the LUPAs.

3 DR. MARK MILLER: [Off microphone.] Can I just
4 make one point? You know, Tom, one appeal I would make to
5 you, and given your past and the positions that you've held
6 in the past, is if you see clearly now this notion just as
7 illustrated, and we talked extensively in the rural report
8 that it isn't about money, you know, to every rural. It's
9 about targeting what problem. I mean, that's a message that
10 you could carry into the rural community, because I've got
11 to tell you, it's not punching through.

12 DR. DEAN: [Off microphone.]

13 DR. MARK MILLER: I just -- you know, every little
14 bit. That's all I'm saying.

15 DR. COOMBS: I was just curious, have any of the
16 health agencies expressed to you hurdles about being in a
17 bundled payment or global payment?

18 MR. CHRISTMAN: You know, I've had mostly informal
19 conversations with them about this, and I would say that,
20 you know, similar to all providers, with numerous reform
21 efforts underway, they see both threats and opportunities
22 and are trying to think about where they fit in. And I

1 certainly do detect an eagerness in those areas where they
2 think they can improve care, they want to be a part of it.
3 But as other folks have mentioned, some of these models, you
4 know, change their markets in ways that there may be an
5 exclusive provider for, or exclusive home health agency for
6 a given hospital, and you could understand how that might
7 make them nervous.

8 DR. REDBERG: I just have a comment, so I'll --

9 MR. ARMSTRONG: What are the capital requirements
10 for home health agency, and what would that be one of our
11 criteria?

12 MR. CHRISTMAN: Yes. This is less capital
13 intensive than other sectors. I mean, certainly, they want
14 to have cash on hand. I think the big things that people
15 mention are back office systems, ID, and things like that.
16 There's actually, relative to -- a lot of home health
17 agencies, because of the OASIS and the electronic data
18 requirements --

19 MR. ARMSTRONG: Information technology.

20 MR. CHRISTMAN: -- they've gone to electronic
21 point of care and things like that. And in some ways, I
22 think there are some agencies who are probably leaders

1 relative to any category or provider and use elaborate back-
2 end systems to manage care, to move all the required
3 information they have to move. You know, for them, it's a
4 way of ensuring that their records are both portable and
5 secure when it works out.

6 MR. ARMSTRONG: I don't know of a proposal, but I
7 just wonder if that's really that helpful of a criteria for
8 us. I know it's our standard, but it's just worth
9 considering.

10 And then another question, I don't know how to
11 frame it exactly, but there's a lot of talk now about the
12 idea of a hospital at home kind of a program, which, I think
13 generally speaking, is just an expansion of the use of home
14 health services to more acutely ill patients, is what I'm
15 assuming. So how does the payment structure that exists
16 today that we're talking about tweaking encourage or
17 discourage that kind of use of home health?

18 MR. CHRISTMAN: Well, I guess what I would say is
19 to the extent that somebody -- that you want to run a
20 hospital at home program and that those patients also meet
21 Medicare's coverage standards, you could run a hospital at
22 home program inside of the current payment system, though

1 it's not deliberately set up to accommodate it. I think the
2 catch is when people want to use new models of care,
3 probably the skilled care requirement is relatively easy to
4 meet if they've got a decent model. But I think that the
5 hitch people run into is the homebound point, you know.

6 So in the hospital at home program, you could say,
7 you know, I want to provide you this expanded basket of
8 services, case management and social worker and aide
9 services, but in order to do that, you can't leave the home
10 very often. And for some beneficiaries who are at that
11 point functionally, this could be -- that could work out
12 fine. But there might be beneficiaries that benefit from
13 such a program who don't meet the homebound requirement.
14 You would not be able to do it.

15 MR. ARMSTRONG: So there are aspects of the
16 payment policy that exist that would discourage the
17 advancement of that kind of a --

18 MR. CHRISTMAN: Not permit it, yeah.

19 MR. ARMSTRONG: Yeah. Thanks.

20 MR. HACKBARTH: So if -- where I thought you might
21 be going, Scott, is that with the terminology, hospital in
22 home means to me is a home health agency with really robust

1 capabilities of some sort. And one of our challenges in
2 this broad area of post-acute care is that home health
3 agencies may differ in their capabilities. Skilled nursing
4 facilities may differ in their capabilities. And, in part,
5 the variation is a function of what the other resources are
6 in the community. So in a community that doesn't have any
7 long-term care hospitals, you might have SNFs, for example,
8 and maybe home health that look very different and have more
9 robust capabilities because they're filling a void that in
10 other communities is filled by a separate institutional
11 type.

12 None of our payment systems recognize these
13 differences in capabilities for post-acute providers, and so
14 one path you could go is to say, well, if the idea of
15 hospital at home takes off, we've got to do that outside, or
16 at least as a separate adjunct to the home health payment
17 system. And then we get still another type of silo.
18 Another approach is to say that if there are care delivery
19 innovations of that sort, we're not going to build still
20 more silos and separate payment systems. They need to
21 happen under the umbrella payment systems, like ACOs. It
22 may be a very good idea. It may make great sense for a

1 hospital to invest in those capabilities in partnership with
2 a home health agency, but we can't proliferate unique
3 payment systems for all of the innovations that might occur.

4 MR. ARMSTRONG: That was really a second round
5 question or comment, but I just don't know if it's good or
6 bad if there are more services, or if the volume increase
7 has leveled off, whether that's good or bad. And then
8 inside of that, this variation in what's -- I run a huge
9 home health agency and we're pushing very hard to create
10 this hospital at home kind of a program, but I just don't --
11 within this payment structure, I just -- I don't -- the
12 incentives are very -- I just don't think -- anyway --

13 MR. HACKBARTH: Yeah. I confess that I've
14 sometimes wondered whether it ever made sense for Medicare
15 to have a separate payment system for home health, or
16 perhaps, alternatively, we should have only paid for home
17 health services in combination with other services, in
18 combination with hospital or in combination with a physician
19 that has ongoing responsibility for coordinating care. To
20 have it as a separate silo -- Mike?

21 DR. CHERNEW: That horse has left the barn. We're
22 trying to get it --

1 MR. HACKBARTH: Yeah. That horse has left the
2 barn, yes.

3 [Laughter.]

4 DR. CHERNEW: I was going to just comment about
5 the --

6 DR. MARK MILLER: [Off microphone.] Thank you,
7 Mike.

8 DR. CHERNEW: I wanted to comment on the capital
9 requirement portion of what Scott said, and this is -- I'm
10 going to say this probably as a comment, but it's really a
11 question to make sure what I said is right. I think the
12 access to capital section is really just used loosely and
13 it's a place where, in terms of payment adequacy, we look
14 at, is there entry into the industry and is there not. So
15 while capital is relevant more so for some than others, it's
16 also the place where we look at are home agencies entering
17 or not.

18 And so the last bullet on that Slide 11 captures
19 something that's not really access to capital per se, even
20 if you needed capital. It's capturing a broader point that
21 there's a lot of entry into this industry, and that says
22 something, capital or not, about the adequacy of payment.

1 MR. ARMSTRONG: Well, not to interrupt this round
2 of our work, but maybe next year we ought to think about
3 whether there's a different label for it.

4 DR. HOADLEY: I just wanted to pick up where Tom
5 started, on the improvement standard question, and just
6 really wondering kind of the same question I asked on SNFs.
7 Is there anything about what we've said already in terms of
8 rebasing that could anticipate -- I mean, maybe this is
9 something you can't even think about until next year, but is
10 there anything that can anticipate sort of being ready for
11 changes that the elimination of the improvement standard can
12 bring.

13 MR. CHRISTMAN: I guess the, you know, the work
14 we've done in SNF is actually somewhat parallel to home
15 health, as well. I mean, we want to make -- we're currently
16 concerned that the payment system is set, in part, based on
17 the types of and amount of visits people provide. When
18 those new patients come in, we want to ensure they get
19 services that are appropriate based on their characteristics
20 and not the incentives. So that would be one thing.

21 I think the second thing is, you know, we're
22 always worried about the appropriateness of services in this

1 sector, and having rates that are, on average, so far in
2 excess of costs, you worry that that creates an incentive --
3 sort of piles on. The improvement standard will liberalize
4 things and people who are disproportionately focused on that
5 margin may see that as more of an opportunity than it really
6 should be.

7 But I think the challenge, Jack, is we don't know
8 how many people are going to come in off the street as a
9 result of this, and that's really, I think, a question. It
10 may be significant, but we'll see what happens and maybe
11 we'll have a better sense once the new guidance rolls out.
12 But we won't really see until agencies are implementing it
13 and claims are getting adjudicated how this is kind of
14 shaking out.

15 DR. HOADLEY: I think anything we can say to sort
16 of just flag this as an issue is probably useful. And, of
17 course, it's going to get us potentially further away from
18 the sort of post-acute framework that we've been also
19 talking about because these are people who are probably
20 farther down the line from the acute care you talked about
21 before. You know, if there's a bunch of episodes, it maybe
22 ultimately started with acute care, but they've gone on and

1 continued. Well, this could just keep that going further,
2 as well, as people who never had an acute care link.

3 DR. NAYLOR: So, briefly, I -- this is in
4 reference to the Chairman's recommendation, and I am
5 concerned about action on this recommendation at this point
6 in our time, even though I supported it last year. So I
7 think that really effective and efficient home health can
8 help move high-risk, vulnerable Medicare beneficiaries to
9 lower risk if effectively applied, and I would be -- and we
10 have so much going on right now. We have hospitals with
11 rehospitalization penalties that just started in October
12 that are going to change this year. We have community-based
13 care transitions program that are trying desperately to
14 figure out how to link hospitals with the efficient,
15 effective home care and community-based organizations.

16 And so I would just want to make sure that
17 whatever we're doing in terms of update really doesn't in
18 any way interfere with the kind -- you know, what has been
19 unleashed in terms of care, system redesign. The
20 Accountable Care Organizations are looking for the kinds of
21 service delivery in the home.

22 So I'm wondering whether or not PPACA's

1 recommendations to start something in 2014 would give us a
2 little bit more time to look at -- and they're talking about
3 3.5 percent reductions for four years -- would give us a
4 little bit more time to see how things are shaking out.

5 I do think that, ultimately, this should be always
6 about performance, and performance of a system that's
7 aligned with people's needs over the most vulnerable times.

8 MR. HACKBARTH: Mary, not to be argumentative, I
9 want to just explore this with you for a second. So in
10 defense of home health payments, the argument is often made
11 that good home health is really important, and it can be
12 very good for patients and it can save money, too. And I
13 want to be clear, I'm a believer. I accept that and I think
14 it could even play a larger role in the future.

15 The hang-up for me has been how does just paying
16 above costs for every episode of home health actually
17 advance the goal of better home health, because persistently
18 high margins, what that means is they're not reinvesting the
19 money in improving home health. If they reinvest it, then
20 the costs would go up and the payments would come in line
21 with costs. We're paying more and the money is being taken
22 out of the system to go someplace else.

1 And so I'm not sure I see the connection between
2 maintaining high levels of payment, way above costs, and
3 getting to the more robust home health system that you and
4 I, I think, probably jointly seek.

5 DR. NAYLOR: I'm not sure that -- I mean, I
6 totally agree with your statement and I don't know enough
7 now to know -- I mean, I'm just expressing what I'm
8 concerned about, that we would implement a recommendation
9 that has to do with rebasing home health rates and
10 eliminating the annual update, would it in any way -- all I
11 want to know is, would it in any way affect those visiting
12 nurse services or others that are doing the most important
13 things for the vulnerable people, and in some ways then
14 negatively affect not just the beneficiaries, but the
15 program. I mean, this is about reducing hospitalizations,
16 rehospitalizations, and everybody is on board with that
17 right now and I just want to make sure that we don't -- that
18 whatever recommendation is aligned with that. So I'm not
19 sure that I won't support this. I'm looking forward to the
20 extra work.

21 DR. HALL: Well, I think we -- I would speak in
22 support of this, if for no other reason than we have to keep

1 the infrastructure that's invested in home health care
2 going. But I hesitate to say this, sitting on the left hand
3 of the maven of transitions in the United States, but I
4 think we should put in an additional recommendation that
5 maybe it's time to start looking at the advisability or the
6 -- yeah, the advisability of having a much closer alignment
7 between home health care agencies and the health care
8 systems that they serve. Maybe the free enterprise system
9 here is really working against us in the modern health care
10 system and where everything else is going. And so maybe
11 there could be a two-pronged approach here.

12 MR. GEORGE MILLER: I share the comments that have
13 been made, particularly with strengthening the home health
14 component to be part of the system. I like that notion and
15 the comments that have been made, particularly what I
16 mentioned earlier and what Herb was reading from. We have -
17 - unfortunately, we have a system that is little capital to
18 get in and there's just five States that have driven half of
19 the aberrant behavior, or appears to be the aberrant
20 behavior. So coupling within the system bundled payments or
21 ACO payments makes sense as we try to transition from silos
22 to comprehensive care.

1 DR. SAMITT: I think you know where I am on this.
2 I support the recommendation, although I think we, as others
3 have said, we need a bridge between the silos and it doesn't
4 feel like there is one to home health care at this point.
5 And what the challenging part of it is that the payment
6 recommendation doesn't sit within the home health care
7 world. It may sit in some of the other realms to engage
8 home health. So I think we'll need to collectively put some
9 more thought around it.

10 The only other thing, though, that was discussed
11 that troubles me is the rural add-on, and I do wonder
12 whether we need to make a policy recommendation regarding
13 linking the rural add-on only in the setting of low volume,
14 and maybe there's a redirection of resources to support that
15 and maybe that should be a slight modification.

16 DR. NERENZ: I'm basically okay with the
17 recommendation. The only additional comment I'd make is
18 that I would like to seek opportunities here, if it's
19 appropriate to also comment on the underlying cost for which
20 the payment is supposed to be adequate, and maybe this comes
21 in this report, maybe it comes elsewhere, but let me go back
22 to my OASIS question, which is where I was trying to get

1 here.

2 A couple of years ago, we were trying to work on a
3 very -- a program on preventing readmissions related to
4 falls, and in that planning in the context of an integrated
5 system, we wanted a really tight, really lean home health
6 component, three or four visits, but focused very tightly on
7 falls prevention. The requirement to do this intake
8 assessment was a deal killer that unraveled the whole thing,
9 because in order to receive Medicare payment for this
10 component, this elaborate assessment had to be done, which,
11 frankly, in this situation was not needed.

12 Now, we could debate this over dinner or
13 something, but the general point would be when we talk about
14 the adequacy of payment, we're talking about the adequacy of
15 payment to cover a set of costs, and my point is that not
16 all those costs are truly value-added for the beneficiary.
17 Here's an example. I think we see it in some of the other
18 things we talk about. So at least, as a general point, I'd
19 say when we make our statement about payment adequacy, I'd
20 like also, if possible, to accompany it with things about
21 how the underlying costs could conceivably be reduced.

22 MR. HACKBARTH: Yeah. Is there anything you

1 wanted to say about OASIS and --

2 MR. CHRISTMAN: I think that the way the home
3 health -- I could see how that would unfold the way you laid
4 it out, David. I think that the home health payment -- the
5 home health system, I think -- and this came up in
6 conversation with Scott -- it's strength is you can do a
7 variety of different things, different business models under
8 the current home health benefit. There's a lot of
9 flexibility. But if you want to do a relatively simple,
10 focused three-four visit, yeah, that a lot of the -- a full-
11 blown assessment where they're going to do -- trying to
12 build sort of the clinical background to do a full case-
13 managed 60 days worth of care is kind of overkill. When you
14 want to do something relatively simple, it may not fit. And
15 whether there's sort of a -- we've talked about this
16 informally, whether there's sort of a low home health
17 benefit that you could come up with has been something we've
18 talked about informally.

19 DR. BAICKER: So, first of all, if that's what
20 we're talking about over dinner, then I'm not coming.

21 [Laughter.]

22 DR. BAICKER: I think this --

1 DR. NERENZ: I just was not trying to belabor this
2 discussion now.

3 [Laughter.]

4 DR. BAICKER: I think the reason that this is such
5 a struggle for all of us is that home health really embodies
6 a lot of the things that we see as shortcomings with the
7 overall system that are hard to fix in this update siloed
8 framework, and that's in part because there's huge
9 heterogeneity of the benefits that accrue to somebody
10 receiving these services, and along with that, there's a lot
11 of preference-sensitive care consumption or there's really
12 elastic demand, so that we think that there's a huge
13 opportunity for these services to be dialed up or down based
14 on the payment, yet they provide sometimes incredibly
15 valuable benefit to the beneficiaries and sometimes a much
16 lower benefit, and the question is how do we design -- how
17 do we reform the payments to promote the higher value use
18 and ensure access to that and discourage the other kind of
19 use, and the answers have to come through a combination of
20 changing the way the payments interact with other parts of
21 the system, and we've talked about the hospitals and we've
22 talked about their post-acute care and changing the way that

1 beneficiaries pay for those services and neither of those is
2 really on the table right now for today's discussion.

3 So the recommendation looks good with those
4 constraints, but those constraints are particularly binding
5 and rankle particularly in this instance of care that has
6 those features, and I think that's part of why we're all so
7 uncomfortable with the current state of affairs.

8 MR. BUTLER: So I can support, and particularly
9 because the cost of entry and exiting this business is not
10 capital intensive, I am convinced that we could make
11 adjustments to accommodate any unintended consequences of
12 the rebasing.

13 DR. CHERNEW: Yeah. I also agree, and I would
14 just say the other thing that makes this so hard is the
15 heterogeneity in the providers. And every time there's a
16 lot of heterogeneity in the providers, we always worry about
17 what goes on, because we don't want to hurt some because
18 we're trying to get average payments right one way or
19 another, and that just makes it really hard. So I don't
20 have much more to say about that beyond what's been said, so
21 I'll just say I support the recommendation.

22 MR. KUHN: Yes, I support rerunning the

1 recommendation again. Just one quick question. In a
2 previous meeting, we talked about the beginning work of
3 rehospitalization, recommendation for home health overall.
4 That is work we'll probably come back to in the spring, I
5 assume?

6 MR. HACKBARTH: Readmission?

7 MR. KUHN: Readmission, yes, rehospitalization.
8 So okay. So that won't be part of this, but as a subsequent
9 conversation.

10 MR. HACKBARTH: [Off microphone.]

11 DR. MARK MILLER: May I try and link it to some of
12 the comments of --

13 MR. KUHN: Yeah. I think that would be great.
14 Thanks.

15 MS. UCCELLO: So I support the recommendation, and
16 I'm also wondering whether it makes sense here to reiterate
17 our recommendations regarding getting rid of the therapy
18 thresholds and basing payments on the patient
19 characteristics.

20 MR. HACKBARTH: I'm sorry, I didn't hear the, sort
21 of the middle part. At least get to what?

22 MS. UCCELLO: Do we also want to reiterate our

1 recommendations regarding getting rid of the therapy
2 thresholds?

3 DR. MARK MILLER: The PPS reforms.

4 MR. HACKBARTH: Oh, yeah.

5 DR. MARK MILLER: That's what she's talking about.

6 MR. HACKBARTH: Mm-hmm.

7 DR. MARK MILLER: We can -- I mean, this is a
8 decision. We can certainly rerun the whole array of
9 recommendations, if that's what you guys want to do.

10 MS. UCCELLO: I mean, I think, given all the
11 concerns that everybody has, putting those aside, and I
12 agree with those, it just seems that there is an increased
13 urgency of -- given this is what we have to do, we need --
14 the increased urgency, I think, comes from the court's
15 agreement and that this could be, you know, increased
16 utilization, in general, of these services. And so it's
17 more important to make sure the payments are right.

18 DR. DEAN: I guess I would share Mary's hesitation
19 and Bill's comments about, you know, we somehow have to
20 figure out a way to tie this very valuable service into the
21 broader system, and we're obviously doing a pretty poor job
22 of that right now.

1 It seems to me, as I was thinking about it, you
2 know, this improvement standard is one challenge, although
3 we sort of have two populations here. We have that group of
4 people that are just coming out of the hospital, they need
5 some help, they need to get back on their feet, they need
6 some therapy, they need some strengthening, those things.
7 They're limited in terms of how long they're going to be on
8 the program. On the other hand, we have the people that I
9 think Mary alluded to that have serious chronic disease that
10 may well very legitimately and appropriately need this
11 service for a very long time, and I think most likely you
12 can justify that from a cost effective point of view if it
13 really is focused and delivered to that limited group of
14 people. But we haven't figured out quite how to do that.

15 I guess I struggle because, on one hand, we
16 obviously have some margins here that are really bothersome.
17 On the other hand, we also have, apparently, 25 percent of
18 the agencies that are losing money. And somehow, we've got
19 to figure out how to sort out which of those are really
20 delivering a service and providing value and which of them
21 are just taking money out of the Medicare program and I
22 don't think we've figure out how to do that.

1 So maybe we can't -- I understand, we can't do it
2 with this update mechanism. On the other hand, I think it
3 does argue that we really need to at least in the text make
4 sure that we try to send the message that this is a poorly
5 targeted benefit right now.

6 MR. HACKBARTH: I think what we can do, and this
7 goes back to Cori's suggestion, is that in both home health
8 and skilled nursing, where we've recommended rebasing, we've
9 also made a point of saying that the payments are currently
10 maldistributed. And so we've coupled rebasing
11 recommendations with improve the payment system and make it
12 more accurate sort of recommendations. And what these
13 comments suggest to me is continuing to couch rebasing in
14 that form.

15 We've got two types of problems. The average
16 level is too high, and then, second, the dollars are not
17 well distributed. That may be a factor in some agencies
18 losing money. I can't guarantee that, obviously, but it
19 could be a factor. So agencies that are doing all the right
20 things are just not getting paid adequately for it and so
21 they end up losing money.

22 Alice.

1 DR. COOMBS: I support the recommendations. I was
2 thinking about something that Bill said at the last meeting
3 when we were discussing this very issue. I think that in
4 the ICU, particularly, we actually have people who elect to
5 go home and some of them are on bipaps, some of them are
6 going to be vented in their living room. And so you almost
7 have to, going forward, consider the different types of
8 patients that are being treated and actually categorize them
9 in, you know, like high-intensity, low-intensity, and I
10 think we have an opportunity to do that going forward.

11 DR. REDBERG: I think, like others have said, home
12 health care is a very valuable service when used
13 appropriately, and so it's a shame, like for other things,
14 that there are issues of fraud, waste, and abuse and other
15 things that color and make it harder. But it does seem
16 particularly that's accentuated by this kind of siloed fee-
17 for-service model, and so all of the suggestions where it is
18 bundled, where really the goal is to help our beneficiaries
19 get better and feel better, which I think home health plays
20 an important part, so if that's a bundled ACO or those sort
21 of payment models would be a great way to handle it to
22 incorporate it.

1 And just if OASIS is really 30 pages, I would
2 consider that that's a little burdensome and onerous. I'm
3 all for quality measurement, but that seems a bit much.

4 I support the Chairman's recommendations.

5 MR. ARMSTRONG: For the same reasons, I support
6 the recommendations. I just would add that while I think,
7 in the right system, investing even more aggressively in
8 home health will offer a huge return in terms of overall
9 health and total costs and so forth, I don't think we need
10 to wait at all to conclude that the Medicare program is
11 overpaying on a per unit of service basis for these services
12 right now.

13 DR. HOADLEY: Yeah. I'm supportive of the
14 direction and really sort of endorse these various comments
15 about anything we can say about some of these revisions or
16 concerns going on would be good, as well as making -- it
17 would be useful to be very clear in the report how this
18 relates to what's already called for in the Affordable Care
19 Act. Just make sure it's clear how this overlays with that.

20 MR. HACKBARTH: So when Carol began the discussion
21 of skilled nursing and home health, she gave a brief
22 presentation, introduction to Medicare payment updates for

1 the post-acute sectors, and I think in that sounded some
2 important themes that have now echoed again through this
3 conversation.

4 Is the plan, Mark, when we get to producing the
5 chapters for March, to have text that is a prelude to the
6 chapters on home health and SNF and other post-acute
7 providers talking about some of these issues? I know we've
8 done that before, and we could even pirate some of the
9 things that we've written before. But I really think that's
10 important context for talking about these payment systems.

11 DR. MARK MILLER: It is the plan now.

12 [Laughter.]

13 MR. HACKBARTH: Oh, good. I'm glad to hear that.
14 You're always ahead of me.

15 DR. MARK MILLER: I'm looking right at Carol.

16 Yes.

17 MR. HACKBARTH: Yeah. So we'll do that.

18 You know, I'm going to beat the payment reform
19 drum one last time. We and many others talk so much about
20 how we need to move away from fee-for-service, and nine
21 times out of ten, the point that is emphasized there is that
22 fee-for-service creates all the wrong incentives, the

1 incentives for increased volume and intensity and not for
2 value and doing better things for patients. And, of course,
3 I agree with that.

4 But on my list of problems with fee-for-service,
5 almost as high as that is that the fee-for-service system,
6 especially as operationalized through these silos, a problem
7 just as big is that it impedes the free flow of resources to
8 where they can do the best thing for patients. It creates
9 boundaries. It creates seams. It creates obstacles in
10 terms of rules and regulatory requirements. And we would be
11 much better off if we had clinicians decide -- clinicians
12 who know the patient, know what the needs are, matching them
13 with appropriate home care, for example, potentially the
14 home hospital if that works for the patient.

15 We've got to get beyond this siloed payment system
16 in the interest of quality for patients. Forget all the
17 incentives about volume and all that stuff. We've got to
18 get the resources flowing more freely to meet patient needs.
19 So that's my speech for today.

20 Thank you, Evan. We appreciate your good work on
21 this.

22 Now, we'll have our public comment period for

1 anybody who has had the endurance to stay with us.

2 [No response.]

3 MR. HACKBARTH: Okay. Seeing none, we are
4 adjourned until 8:30 tomorrow morning.

5 [Whereupon, at 5:52 p.m., the proceedings were
6 recessed, to resume at 8:30 a.m. on Friday, December 7,
7 2012.]

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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 7, 2012
8:32 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [8:32 a.m.]

2 MR. HACKBARTH: Good morning.

3 So this morning, we will conclude our
4 consideration of draft recommendations on updates.

5 For the audience, let me just say a few words
6 about the context. These are draft recommendations that
7 we'll be discussing today, draft recommendations that I am
8 offering for consideration by the Commission. Based on the
9 discussion today and conversations I have with individual
10 commissioners between now and the January meeting, we will
11 formulate final recommendations for a vote in January.

12 Under the statute that created MedPAC, our task is
13 to advise the Congress on payment rates that are consistent
14 with the efficient delivery of services after considering
15 the effect of our recommendations on the Federal budget.
16 Ultimately, we want to assure that our proposed rates do not
17 impede access to quality care for Medicare beneficiaries.

18 Those of you who have followed our work in the
19 past know that we use a multi-part payment adequacy
20 framework, which you will see in evidence as we go through
21 each of the presentations this morning. Our approach to
22 considering the updates is that we begin with the current

1 rates, the prevailing rates, and then ask the question
2 whether there is evidence that would justify either an
3 increase or decrease in the prevailing rate.

4 In other words, we do not use an approach that
5 says the starting point is market basket minus productivity,
6 or whatever the relevant measure is in the Medicare statute.
7 Instead, we start with the current rate and ask whether it
8 should be increased or decreased based on the available
9 payment adequacy evidence.

10 This year, the sequester creates different
11 questions than we usually face about payment rates, and so
12 we're going to take a minute and explain how the sequester
13 plays into the consideration of payment updates.

14 Kate?

15 MS. BLONJARZ: So the Medicare sequester starts in
16 February 2013 and cuts 2 percent from nearly all provider
17 payments. This slide shows how that works.

18 The sector receives a statutory update each June
19 and the yellow line shows the payment amount in the absence
20 of the sequester. The dashed green line shows their payment
21 amount when the sequester begins in February 2013.

22 The updates the Commission is considering today

1 are based on the yellow line. They are updates to the base
2 rate.

3 The presence of the sequester will affect the
4 savings estimates for the Commission's recommendations. In
5 the first example, a sector has a base rate of \$100 in 2013
6 and the statutory update of 1 percent. In 2014, their
7 payments increase by \$1 for the update and decrease by \$2
8 for the sequester, to \$99. If the Commission recommends a 1
9 percent update for 2014, this would update in a payment
10 amount of \$101. Compared with the sequester baseline, the
11 Commission's recommendation would have a cost.

12 The second example shows a sector with a base
13 rate, again, of \$100 and a statutory update of 1 percent.
14 Again, the sequestered amount for 2014 is \$99. But for this
15 sector, the Commission's recommendation is a negative 2
16 percent update, resulting in a payment rate of \$98.
17 Compared with the sequester baseline, the Commission's
18 recommendation has a cost.

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

22 MR. HACKBARTH: Thanks Kate.

1 So let's now turn to inpatient rehabilitation
2 facilities.

3 MS. SADOWNIK: Good morning. In this
4 presentation, we will discuss the adequacy of Medicare
5 payments to inpatient rehabilitation facilities, or IRFs. I
6 will present data on a range of indicators of payment
7 adequacy and then review a Chairman's draft recommendation
8 for payment rates for fiscal year 2014.

9 IRFs provide intensive rehabilitation services,
10 such as physical and occupational therapy and rehabilitation
11 nursing, to patients after an injury, illness, or surgery.
12 IRFs may be specialized units within an acute-care hospital,
13 or they may be free-standing hospitals. Hospital-based IRFs
14 represent 20 percent of facilities, but they account for
15 only 55 percent of Medicare IRF discharges. Relatively few
16 Medicare beneficiaries use IRFs because patients must be
17 able to tolerate the intensive therapy. Nevertheless,
18 Medicare fee-for-service is the principal payer for IRF
19 services, accounting for 62 percent of total cases in 2011
20 and almost \$6.5 billion in spending. Since 2002, IRFs have
21 been paid on a per discharge basis where rates vary based on
22 patients' conditions and severity of illness, as well as on

1 certain facility characteristics.

2 IRF patients must require at least two types of
3 therapy, one of which must be physical or occupational
4 therapy, and patients must be able to tolerate and
5 reasonably be expected to benefit from three hours of
6 therapy per day for at least five days a week. To qualify
7 as an IRF, facilities must meet certain criteria. In
8 addition to meeting the Medicare conditions of participation
9 for acute-care hospitals, IRFs must have a medical director
10 of rehabilitation on a full-time basis, have a preadmission
11 screening process for patients, and use a coordinated
12 interdisciplinary team approach led by a rehabilitation
13 physician. Rehab physicians must be involved in pre-
14 admission screening, post-admission evaluation, and
15 development of individualized care plans.

16 In addition, IRFs must meet a compliance threshold
17 which stipulates that no fewer than 60 percent of all
18 patients must have at least one of 13 conditions, although
19 determining compliance can be complex. Because IRFs are a
20 more costly setting for post-acute care (compared to SNFs
21 and home health), CMS developed the compliance threshold to
22 ensure that IRFs treat patients who are appropriate for this

1 setting. Trends in volume and patient mix have been
2 sensitive to policy changes in compliance criteria. After
3 the compliance threshold was renewed at 75 percent in 2004,
4 IRF volume, occupancy rates, and the number of beds
5 declined. The share of cases with conditions that count
6 towards the compliance threshold increased, and the share of
7 major joint replacement cases, in particular, declined. We
8 saw a large shift in the post-acute care settings for major
9 joint replacements. Hospital discharges shifted away from
10 IRFs for these cases and to home health agencies and SNFs.
11 In 2007, the compliance threshold was capped at 60 percent,
12 and the industry began to stabilize.

13 We will use the same framework to analyze payment
14 adequacy for IRFs as for the other sectors, including access
15 to care, quality of care, access to capital, and payments
16 and costs.

17 Let's start with access to care. I will review
18 the supply of facilities and beds, as well as occupancy
19 rates and volume of services. With respect to supply, as
20 you can see here, there were 1,165 IRFs in 2011. Between
21 2010 and 2011, the total number decreased by 14 facilities,
22 or a little more than 1 percent. The total number of IRFs

1 has declined every year since 2005, which reflects a trend
2 of hospital-based facilities leaving the market and the
3 number of free-standing facilities slowly increasing. The
4 supply of IRF beds largely follows this trend too, although
5 the number of beds in free-standing facilities also declined
6 very slightly in 2011. Note that while free-standing
7 facilities make up only 20 percent of IRF facilities, they
8 represent about 40 percent of all IRF beds, due to the
9 higher average bed size per facility.

10 Occupancy rates represent another measure of IRFs'
11 capacity to serve patients. In 2011, occupancy rates rose
12 modestly to 63.3 percent. Although rates fell slightly in
13 2010, they have risen most years after 2007. Occupancy
14 rates were higher in free-standing IRFs than in hospital-
15 based IRFs and higher for IRFs in urban areas than those in
16 rural areas. These occupancy rates suggest that capacity is
17 adequate to handle current demand and can likely accommodate
18 future increases.

19 Now that we've reviewed capacity, let's turn to
20 trends in volume as well as payment. This chart presents
21 the number of fee-for-service cases, payment per case, and
22 total fee-for-service spending. While the number of cases

1 dropped in 2010, cases rebounded in 2011 by 3.3 percent.

2 Note that volume has been increasing even as the number of
3 beds has decreased, suggesting that beneficiaries are not
4 losing access to services overall.

5 Fee-for-service spending totaled an estimated
6 \$6.46 billion in 2011, an increase of 5.2 percent. The
7 sharp increase in spending reflects the growth in number of
8 cases and in payment per case, which increased by 1.8
9 percent in 2011. Factors that impact the growth in payment
10 per case include a 2.25-percent update to the base rates in
11 2011, a 0.9-percent decrease in outlier payments, and 0.3-
12 percent increase in patient severity.

13 Turning to quality of care, we worked with RAND to
14 measure IRF quality through five risk-adjusted measures that
15 cover functional improvement, where the beneficiary is
16 discharged to, and readmissions. Mostly we see stability in
17 IRF industry performance from 2009 to 2010. The amount of
18 functional improvement (or FIM gain) decreased moderately.
19 While the rates of being discharged back to the community
20 got very slightly better, rates of admission to a SNF within
21 30 days after discharge got very slightly worse. We had two
22 measures of acute hospital readmissions: being discharged

1 directly back to the hospital and being readmitted within 30
2 days after discharge to the community. On both, we see
3 essentially no change.

4 Access to capital is another measure of payment
5 adequacy. Hospital-based units have access to capital
6 through their parent institution, and as we heard during the
7 inpatient hospital presentation yesterday, hospitals have
8 overall maintained reasonable levels of access to capital in
9 2011. We have also seen a continuing industry focus on
10 shifting capacity to the outpatient setting. As for free-
11 standing IRFs, we review access to credit for one major
12 national chain, which shows that their ability to borrow has
13 increased, largely due to improving credit markets and the
14 chain's strong operating performance. Besides this chain,
15 most other free-standing facilities are independent or
16 smaller chains with only a few providers, and it is less
17 clear how much access to capital these providers have.

18 I will now go over IRF margins for 2011 and then
19 discuss factors that drive these margins. Overall margins
20 were 9.6 percent in 2011, up from 8.7 percent in 2010. We
21 see that margins vary substantially between hospital-based
22 and free-standing IRFs. Free-standing IRFs had margins of

1 almost 23 percent in 2011. They represent about 44 percent
2 of Medicare spending. In contrast, hospital-based IRFs had
3 margins of negative 0.8 percent, and their average margins
4 have been decreasing since 2009, while margins for free-
5 standing facilities have been increasing. Margins in for-
6 profit facilities were about 21 percent, while nonprofit
7 facilities had margins of 2 percent. Hospital-based
8 facilities that were for-profit had higher average margins
9 than hospital-based facilities that were nonprofit.

10 On the next slides, I will discuss some possible
11 reasons for the differences in margins between hospital-
12 based and free-standing IRFs.

13 As context for this discussion, recall that
14 although hospital-based IRFs constitute 80 percent of all
15 IRF facilities, they account for a much smaller share of
16 Medicare discharges, about 55 percent, due to smaller bed
17 sizes and lower occupancy rates. Therefore, 45 percent of
18 Medicare IRF discharges are in free-standing facilities that
19 have an average of 23-percent margins.

20 Hospital-based IRFs have higher costs than free-
21 standing IRFs. We did not find that their patients are
22 sicker. Instead, reasons include that hospital-based IRFs

1 tend to have fewer beds and lower occupancy rates, which
2 keep them from fully capitalizing on the economies of scale
3 of the more efficient free-standing facilities. Among
4 hospital-based IRFs, both direct and indirect costs were
5 higher than in free-standing IRFs. In 2010, direct costs
6 per case were 30 percent higher in hospital-based IRFs and
7 indirect costs per case were 11 percent higher.

8 However, based on 2010 data, even though Medicare
9 margins for hospital-based IRFs are below zero, on average
10 the IRF units are able to cover their direct costs. The
11 direct cost margin, which is a Medicare margin that is
12 calculated using only direct costs, was 34 percent in 2010
13 for hospital-based IRFs. In addition, overall Medicare
14 margins for acute hospitals are about two percentage points
15 higher for acute hospitals that have an IRF unit than for
16 those that do not have an IRF. These data indicate that IRF
17 units are able to cover their direct costs and financially
18 contribute to their parent hospital.

19 As we have seen, aggregate Medicare margins for
20 IRFs in 2011 were 9.6 percent. To project the aggregate
21 Medicare margin for 2013, we modeled the policy changes
22 driving payment rates for 2012 and 2013. We project that

1 Medicare margins for 2013 will be 8.3 percent. To the
2 extent that IRFs restrain their cost growth, the 2013 margin
3 could be higher than we have projected.

4 In summary, our indicators of Medicare payment
5 adequacy for IRFs are positive. Despite the overall supply
6 of IRFs decreasingly slightly, volume has increased and
7 excess capacity in occupancy rates remain, suggesting that
8 capacity remains adequate to meet demand. Margins average
9 23 percent for the sector of the industry that tends to
10 operate more efficiently. Finally, risk-adjusted quality of
11 care remains stable, and access to credit appears adequate
12 for both hospital-based and free-standing IRFs. We project
13 that 2013 aggregate Medicare margins will be approximately
14 8.3 percent.

15 The Chairman's draft recommendation for your
16 review is: The Congress should eliminate the update to the
17 Medicare payment rates for inpatient rehabilitation
18 facilities in fiscal year 2014.

19 On the basis of our analysis, we believe that IRFs
20 could absorb cost increases and continue to provide care
21 with no update to the 2013 payment rate. Note that this
22 recommendation repeats the one we recommended last year. We

1 estimate that this recommendation will decrease federal
2 program spending relative to current law. We do not expect
3 this recommendation to have adverse impacts on Medicare
4 beneficiaries. This recommendation may increase the
5 financial pressure on some providers, but overall we expect
6 a minimal effect on reasonably efficient providers'
7 willingness and ability to care for Medicare beneficiaries.

8 This concludes the presentation, and Craig and I
9 welcome any questions.

10 MR. HACKBARTH: Thank you, Sara.

11 Could you put up Slide 10, please? So we have a
12 picture here where there's a significant difference between
13 the margins of the free-standing and hospital-based
14 facilities. For the new Commissioners, people may have
15 picked up that in some areas, like home health and skilled
16 nursing facilities, we just focus on the free-standing
17 facility margins and have a payment update based on that.
18 Here we've got a combination of hospital-based facilities
19 and free-standing, and there's a significant difference in
20 the financial performance between the two. So it may just
21 be worthwhile walking through why hospital-based are
22 combined with free-standing here and not elsewhere.

1 DR. MARK MILLER: And I'll start off because he
2 warned me he was going to ask this question and he didn't
3 warn you.

4 [Laughter.]

5 DR. MARK MILLER: So I'm going to tell a few
6 jokes. While I'm doing that, get your thoughts together.

7 This is a conversation we had a number of years
8 ago when we sort of moved into this space because we hadn't
9 -- there was a point at which we came up to IRFs. And there
10 were a few reasons that we did this. The first -- and this
11 is pointed out in the analysis -- is that, unlike the other
12 providers that Glenn mentioned, the hospital-based
13 represents a much more significant proportion of what's
14 going on here; whereas, in the other places it's, you know,
15 5 and 10 and 15 percent, those types of things. And so
16 clearly the model has become dominated by a free-standing;
17 whereas, here the model is not dominated by that.

18 The other thing that we did, because this was a
19 concern, is how the allocation works in a hospital setting,
20 and that has always been a concern of pulling them in. And
21 some of it was historical and sort of when IRFs came along
22 and that type of thing. But when we looked at that -- and,

1 Craig, this is where I'm trying to start to tap the memory
2 banks -- there wasn't as much indication of allocation
3 issues here. And so we also felt like, unlike where you
4 find these stark differences in, you know, indirects in
5 between the hospital-based SNF and a free-standing SNF, we
6 didn't quite find the same patterns here, which also made us
7 a bit more comfortable saying these things are, you know,
8 okay to put together. And what really seems to drive the
9 differences, which you said very clearly, Sara, was there
10 really seems to be more volume occupancy issue on the
11 hospital-based as opposed to a different model of care.
12 That's my rough recollection of what the hell happened
13 several years ago.

14 MR. LISK: You got it right.

15 DR. MARK MILLER: No kidding?

16 MR. LISK: Yeah, you got it exactly right.

17 DR. MARK MILLER: Note the surprise in his voice.

18 [Laughter.]

19 MR. HACKBARTH: Let me ask another question, Sara.
20 This is for Sara. This isn't for you.

21 DR. MARK MILLER: I'm tapped out. I've got to go
22 lay down.

1 MR. HACKBARTH: So could you put up Slide 8? The
2 FIM gain number, as you point out in the paper, that's a 15-
3 percent decline. You know, yesterday we looked at some
4 quality numbers, trend numbers that, you know, were like
5 flat. Here, a 15-percent change in a single year seems like
6 a pretty significant move. You sort of didn't spend much
7 time on that in either the paper or the presentation. What
8 am I missing here?

9 MS. SADOWNIK: Yeah, and it's also worth noting
10 that, you know, while the case mix increased very marginally
11 between the two years, you know, we're not looking at really
12 a difference in case mix that's driving the difference as
13 opposed to maybe in previous years.

14 You know, it's interesting that there was more of
15 a change in FIM gain than in the other measures that we're
16 looking at. I would say that it's worth keeping in mind
17 with FIM gain that this is out of a 100-point scale, so, you
18 know, the difference on that large of a scale may not be as
19 stark as the numbers themselves.

20 MR. HACKBARTH: Okay. So let's see. Scott, do
21 you want to lead off with clarifying questions?

22 MR. ARMSTRONG: Just one. The IRFs in hospitals,

1 do they have to be physically a separate unit, or can they
2 just be some number of beds designed in a particular part of
3 the hospital?

4 MR. LISK: I believe that they're physically --
5 they're a specific unit within the hospital when they're
6 free-standing, so it's designated units. They have the
7 space designated in terms of -- when you even think about
8 the cost allocation, their space is designated space.

9 MR. ARMSTRONG: But it really could be sort of the
10 back end of a nursing unit or -- it's -- I mean, it's really
11 using the other fixed costs of the hospital campus. I mean,
12 I -- a hospital-based IRF I assume looks and feels pretty
13 much like any other nursing unit on a hospital campus. It's
14 not in a separate building and served by support services in
15 a different way?

16 MR. LISK: No. That would generally be the --
17 that would generally be the case. I mean, there may be some
18 exceptions, but generally, yes, it would be a unit within
19 the hospital, so it would be like another unit within --
20 another, you know, wing, you know, portion of a floor of a
21 hospital or something, or a floor of a hospital.

22 MR. ARMSTRONG: And I know there are all sorts of

1 standards around rehab physicians and services like that
2 that would be different from that unit. But physically, you
3 know, it's pretty much a part of that campus. Okay.
4 Thanks.

5 DR. REDBERG: I was also struck by the quality-of-
6 care measures, and I was wondering if we also have some
7 measures that compare the free-standing to the hospitals.
8 Was there a difference in functional improvement there?

9 MS. SADOWNIK: I don't have that number now. I
10 can look on that measure in particular, the difference in
11 performance between hospital-based and free-standing.
12 Overall, we saw higher quality on average in free-standing
13 facilities, just, you know, on average sort of across -- I
14 should say actually higher quality over time, sort of
15 looking at, you know, over three years who were sort of some
16 of the top performers on quality. But in terms of the raw
17 performance, I can look at that.

18 DR. REDBERG: And also, when the compliance
19 thresholds changed from 2002 and 2004 and 2007, was there
20 any sense of patients were doing better or worse when more
21 of them were being treated in other facilities and not
22 inpatient rehab or --

1 MS. SADOWNIK: Are you asking about the, you know,
2 functional improvement in an IRF versus in a SNF or home
3 health?

4 DR. REDBERG: Yes.

5 MS. SADOWNIK: You know, there was some -- the
6 CARE demonstration or the demonstration that was using the
7 CARE tool that had been talked a little bit about yesterday
8 that was trying to use a common measurement tool across all
9 those facilities, was starting to look at that. You know, I
10 can provide more detail on it. I think overall there were
11 some areas that IRFs appeared to be doing better and some
12 that quality was fairly consistent across all of them.

13 DR. REDBERG: I'm just curious because there's a
14 lot of different post-acute care facilities.

15 MS. SADOWNIK: Right.

16 DR. REDBERG: And, of course, we want to allocate
17 patients where they're going to do the best, but it's not
18 clear to me because -- and there have been changes naturally
19 over time in that case mix, so I thought it was an
20 interesting temporal trend to be able to look at the
21 quality.

22 MS. SADOWNIK: Yeah, it's a really important

1 question, and, you know, I think there's -- you know, the
2 CARE tool is starting to look at that, and it's an important
3 area to look at.

4 DR. REDBERG: That's great.

5 My last question. Maybe I'm missing something,
6 but it seems like hospitals would have a lot of control over
7 where they were discharging patients, and I'm surprised that
8 hospital IRF occupancy rates are lower than free-standing
9 because they could preferentially discharge to their own
10 facility. So what am I missing?

11 MS. SADOWNIK: I think that, you know, maybe
12 you're describing a scenario where there are, you know, both
13 hospital-based and free-standing facilities in the same
14 market, and we didn't look at that in particular. This is
15 sort of national averages.

16 DR. REDBERG: I see.

17 MS. SADOWNIK: If that makes sense.

18 DR. REDBERG: Because I only know the Bay Area
19 market, and I believe that's true in the Bay Area, so I
20 assumed it was true nationally, but --

21 MS. SADOWNIK: Yeah. You know, there may be
22 markets where they are sort of competing head to head in

1 markets where there's, you know, a predominance of one
2 versus another.

3 MR. LISK: One of the large national chains
4 actually kind of looks at what the market is, and there have
5 been cases where they've actually bought out the hospital-
6 based IRFs because there's just too much capacity in that
7 market. So there are some cases where I think the free-
8 standing are going in and being in markets where there isn't
9 as much competition may be one of the factors as to why
10 there's higher occupancy rates in those markets. It's a
11 possibility. There could be other factors, too.

12 MR. HACKBARTH: So I would like to pick up on
13 Rita's earlier question about the evidence on improvement
14 across different post-acute providers, and there was a
15 passage in the paper about the CARE demonstration. For
16 January, I'd like to learn more about this. If I'm
17 understanding it correctly, using the CARE tool, there
18 wasn't much difference in improvement across the settings.
19 And yet the average payment per case in IRFs, in 2011 it was
20 \$17,000. Off the top of my head, I can't quote the
21 comparable numbers from a SNF or home health, but I think
22 they would be substantially lower, and correct me if I'm not

1 right about that. And if what we're getting is a relatively
2 small gain in improvement, that's something we need to
3 explore further, in particular, when we see the free-
4 standing IRF margins at 20 percent plus. So I'd like to
5 learn more about that between now and January.

6 DR. MARK MILLER: Could I also -- on the quality
7 point, the two points that I sort of carry around in my
8 head, is on the CARE demonstration, the differences were
9 small or IRFs were maybe a little better. That's kind of
10 what I remember. Then we had some work done by RAND awhile
11 back when all of this was starting to happen, the 60-percent
12 -- or 75-percent rule, which became the 65, which became the
13 60-percent. And it was very difficult to do the work
14 because there was no common assessment instrument. There
15 was all kind of instrumental variable, you know, so in the
16 end there was some indication that there was higher quality
17 in IRFs, but it was very qualified because of the
18 measurement complications you run into.

19 The other thing, Craig, I'm trying to remember --
20 and this is from several years ago, and I could be wrong
21 about this. But wasn't there some work we were looking at,
22 and there was some sense of hospitals selecting who went

1 into their IRF units, and that there was sort of a conscious
2 or detectable difference in the data of who went where, and
3 we can come back to you. But I think the overarching point
4 is that when the compliance threshold came into effect, the
5 industry, you know, kind of contracted and is sort of
6 figuring out which kinds of patients it's going to focus on,
7 because there were a set of patients that now kind of fell
8 outside of the compliance threshold, and that may be more
9 what is being reflected in the occupancy rates than, you
10 know, a selection process. But that's kind of --

11 MR. LISK: I think some of that was the case,
12 particularly, let's say, hospitals that had hip and knee
13 departments, they were doing a lot of -- they were taking a
14 lot of those patients into their hospitals. And when the
15 compliance threshold was reinforced, those patients really -
16 - they couldn't take most of those patients anymore, and
17 that really dropped down the occupancy rates substantially
18 in those facilities over time. And then it has gained back
19 up as they have kind of found other patients to replace
20 them.

21 Some of the free-standing facilities actually had
22 already started not taking those patients as much either as

1 well, so they didn't have as much of a change to effect when
2 that was -- when the -- the word here -- when the compliance
3 threshold was reinforced. So they didn't have as big a
4 change to make as some of the hospital-based facilities in
5 some cases.

6 MR. HACKBARTH: So, can I just go back to the
7 improvement issue for a second, because I may be
8 misinterpreting what's in the paper, and if I am, I don't
9 want to leave that just sitting.

10 So I remember the RAND analysis and their
11 conclusion that was really difficult to make apples-to-
12 apples comparisons. My understanding is that's one of the
13 reasons for developing the care tool, and I thought the
14 research that was being reported in the paper was RTI
15 analysis of a comparison using the care tool, and their
16 conclusion -- well, according to the paper, the risk
17 adjusted analysis found no significant difference in the
18 average degree of improvement of mobility, but a slightly
19 higher gain in self-care outcomes among IRF patients. Where
20 results varied, the difference in improvement among settings
21 was relatively small, less than five points on a 100-point
22 scale.

1 So the way I'm interpreting that is now we have a
2 tool for making apples-to-apples comparison and what we find
3 is a relatively small gain, less than five points on a 100-
4 point scale, and yet we're paying an average of \$17,000 per
5 episode and we've got freestanding facilities that have
6 average margins of over 20 percent.

7 If there's something in that picture that I'm not
8 understanding, I'm eager to learn more about it. So I'll
9 leave it there.

10 Alice.

11 DR. COOMBS: So, one of the things before the
12 compliance thresholds were instituted, a lot of facilities
13 in our area would actually have the IRFs, and in cases where
14 patients were going to have bilateral total knees, they
15 would do a knee, send them to the IRF, and then return them
16 back to the hospital. It made it very convenient for that
17 to happen. So I know that with that threshold compliance,
18 things may have changed as a result of that in that group of
19 patients, particularly.

20 On Slide 10, one of the questions I had was,
21 looking at the division of nonprofit and for-profit, what
22 percentage of the for-profits are hospital-based, or is it

1 100 percent freestanding in that category?

2 MS. SADOWNIK: You're asking what percentage of
3 the nonprofits are --

4 DR. COOMBS: The for-profit are hospital-based.

5 MS. SADOWNIK: It is -- let's see. Of the
6 hospital-based, 16 percent are for-profit. You asked of the
7 for-profit, how many are hospital-based. Let me get back to
8 you on that. I'm going just to crunch that in the other
9 way.

10 DR. COOMBS: Okay, and the same breakdown for the
11 freestanding, if you could break that out, as well. Thanks.

12 DR. DEAN: Just to comment on your comparing --
13 and maybe this is round two, I'm not sure -- but I think
14 that's a really tricky comparison because there's different
15 groups of people going into the two types of facilities and
16 the therapy they get is very different, I mean, in terms of
17 on one hand, so presumably the more complicated patients
18 would go to the IRF. On the other hand, they have to be
19 strong enough to take three hours of therapy, which, at
20 least in my experience, is the thing that excludes a fair
21 number of them.

22 So on one hand, they're healthier, but they also

1 have to qualify for a much more aggressive form of therapy,
2 so it's really tough, I think, to compare outcomes unless
3 you had a way to, in the beginning, select people that were
4 equivalent, but --

5 MR. HACKBARTH: The amount that I don't understand
6 about this is just overwhelming, but my premise, and it may
7 be false, is that the purpose of the care tool was to try to
8 make the apples-to-apples comparison.

9 DR. DEAN: Yeah, and I think that's important --

10 MR. HACKBARTH: Yeah.

11 DR. DEAN: -- because, like I say, just to take
12 the two settings and to compare the outcomes probably isn't
13 fair.

14 MR. HACKBARTH: Well, and the other question I
15 would have is the situation you describe, where the weakest
16 patients don't go to IRFs.

17 DR. DEAN: Right.

18 MR. HACKBARTH: The relatively healthy ones go,
19 the people who can benefit from the therapy. Wouldn't that
20 stack things in favor of the IRFs?

21 DR. DEAN: Well, except that they may have more --
22 they may be healthier, but they may have more severe

1 disabilities, if you can --

2 MR. HACKBARTH: Okay. I see your point. Yeah.

3 DR. DEAN: So they may have had a really bad
4 stroke, but they're still strong enough that they can take
5 that.

6 MR. HACKBARTH: Yeah.

7 DR. DEAN: So it's a very tricky comparison.

8 MR. HACKBARTH: Okay, and let me emphasize again,
9 I'm just trying to understand, so I'm -- Mike.

10 DR. CHERNEW: I agree with that whole discussion.
11 I just wanted to say, in that spirit, one way to think about
12 it would be instead of trying to compare IRF versus other
13 setting patients, to look over time at the entire group of
14 patients and as the mix shifts to see if the entire group of
15 patients is seeing a collective drop or not. There's still
16 going to be some issues, because we have this issue of
17 getting the common tool and stuff, but I think we're moving
18 in the right direction.

19 But I think we could see, as the mix shifts, if we
20 saw a change in quality -- whatever that means -- across the
21 entire group of patients as opposed to trying to compare one
22 group in one setting and one group in another, because

1 that's really what matters, is what's happening to the
2 entire population of patients as the mix shifts or not from
3 one setting to another.

4 DR. DEAN: And your question is absolutely
5 appropriate. It's just -- because we do need to find out
6 what's the most efficient way to get people back on their
7 feet, and whether this three hours of therapy is the right
8 approach or not, I think, is still an open question. So,
9 no, I think it's the right question. It's just tough to get
10 an answer.

11 I guess the clarifying question, on other
12 services, we've seen a lot of geographic variation in terms
13 of availability and cost and all those things. Do you have
14 that information with regard to these facilities?

15 MS. SADOWNIK: In terms of --

16 DR. DEAN: Variation from region to region --

17 MS. SADOWNIK: Yeah, in terms of cost --

18 DR. DEAN: -- about utilization and cost?

19 MS. SADOWNIK: I can get you the cost data, and in
20 terms of -- I'm sorry, did you say utilization or
21 availability?

22 DR. DEAN: Both.

1 MS. SADOWNIK: Both. I can get all that
2 information for you. We did see lower occupancy rates, but
3 in terms of availability, there is at least one in every
4 State, but certainly a concentration in --

5 DR. MARK MILLER: Tom, we can do the utilization
6 rates, you know, looking at -- the way we looked at the
7 geographic variation and use and we can come back to you on
8 that.

9 MR. LISK: You have the map on page four of your
10 mailing material --

11 MS. SADOWNIK: Right.

12 MR. LISK: -- that show you the distribution of
13 IRFs across the country.

14 DR. DEAN: [Off microphone.]

15 MR. HACKBARTH: Okay. I'm going to stay quiet now
16 because I've been a barrier to progress here, so --

17 [Laughter.]

18 MS. UCCELLO: A quick question --

19 MR. HACKBARTH: Everybody else, be better than
20 I've been. Let me put it that way.

21 MS. UCCELLO: A quick question on this functional
22 improvement gain. Has there been a change over time at what

1 the starting point is, because I can see if that changes
2 over time -- you know, how you improve might depend on where
3 you're starting from.

4 DR. MARK MILLER: And I thought the way I would go
5 at this is -- and just make sure that this is right. So
6 what we did is we constructed quality measures with RAND
7 recently and that's what we're reporting here. Is that
8 correct? Okay. And what we were trying to do, or what RAND
9 was trying to do in that analysis is there was a big shift
10 in this industry because of the compliance. So you had a
11 lot of case mix changing, and in a sense, if this is what
12 your case mix looked like, you were sort of moving this case
13 mix out and remaining this. And then at the same time there
14 was some shift in cases that the industry was kind of
15 responding to.

16 In the work that we did with RAND, our attempt was
17 to try and control for the change in case mix in measuring
18 this risk that you see here, with all the usual econometric
19 caveats that other people could do better than me. So we're
20 trying to control for the fact that the case mix is shifting
21 during this time period. Is that fair?

22 MS. SADOWNIK: So last year, we had presented on

1 changes in quality from 2004 to 2009, where, as Mark was
2 saying, there was dramatic changes in the case mix, so it
3 was important to control for case mix over time. In this
4 year, we only compared 2009 and 2010, and in that case, we
5 did not hold the case mix steady in the same way that we did
6 for last year's analysis, for the retrospective over time,
7 but the case mix shift was very small, which was why we
8 didn't. So, you know, certainly because it came more into
9 play there.

10 MR. KUHN: I'm interested in the compliance
11 threshold and access. So in the paper, it talks about an
12 RTI report that CMS -- or CMS contracted with RTI to do a
13 report that came out in 2010, and apparently, in that
14 report, if I understand it right, really couldn't determine
15 whether the compliance threshold was causing issues with
16 beneficiary access to intensive rehabilitation services.

17 At the same time, on Slide 6 that we have here, we
18 show occupancy rates that would be indicative that there is
19 not an access issue.

20 So I'm just curious, what was the criteria that
21 RTI used where they were unable to definitively make a
22 determination? I mean, did they look at -- I mean, if they

1 look at these occupancy rates, I think that would lead them
2 to one conclusion, but I'm curious whether other things that
3 they were looking at access that we ought to be aware of as
4 part of our deliberation here.

5 MS. SADOWNIK: Yeah, I can't speak to that. I'd
6 have to go back to the report and check.

7 MR. BUTLER: First, just as a follow up to Scott's
8 question, we're an example where rehab units are in a
9 separate but physically attached to the main campus
10 buildings. I'd characterize the rehab units in hospital-
11 based are a different infrastructure than, say, like swing
12 beds or a SNF. I mean, you have to have the physical and
13 occupational therapy to meet CARF accreditations. It's a
14 pretty big investment. So it's a little different than just
15 flipping a patient unit, for sure.

16 So I have three questions. None of them are real
17 easy. In the chapter itself, in Table 12, these occupancy
18 rates look pretty stable across the for-profit and the -- I
19 mean, the freestanding versus the hospital-based, and I
20 suspect that that would -- if you went back to 2004, as the
21 Table 12 does, probably, you'd find similar stability. But
22 the profitability in the hospital-based in that time period

1 going from 2004 to 2011 has gone from 12 percent margin for
2 the hospital-based down to a negative 0.8, where the
3 freestanding has kind of stayed about around the 20 during
4 this time.

5 So I struggle with what has happened during that
6 time, because I don't think the units -- I think that the
7 economy of scale issue has existed for that entire period of
8 time, so what is it about the management of these things
9 over that period of time that has changed? This is what
10 still leads me to think that the patient mix issue is a
11 little bit different than what's going on in the two
12 settings. Do you have any thoughts about what would
13 decline? It's not on there, but in the chapter, you've gone
14 from 12 percent margin to zero in hospital-based, again, and
15 stayed the same in the freestanding.

16 MS. SADOWNIK: I don't have a particular insight
17 on that. I think the point that Craig had made earlier
18 about the emphasis on orthopedics, how that may have -- it
19 may have been, you know, more a piece of the hospital-based
20 line of business in terms -- you know, that may have been
21 more integral to their line of business or --

22 DR. MARK MILLER: I think it's --

1 MS. SADOWNIK: -- sort of having integrated care,
2 but besides some of the importance of that, I don't --

3 DR. MARK MILLER: Yeah, I think it's the point
4 that we were talking about. I think, in some cases, these
5 units were more heavily invested in what the compliance rule
6 started to say needed to come out of these facilities.
7 Craig, that's kind of --

8 MR. LISK: I mean, I think that's part of it. I
9 think the other thing is that in terms of the focus, if you
10 think of managerial focus in terms of efficiency and stuff,
11 is when you have this as just part of your facility in terms
12 of the emphasis for the management for controlling the cost
13 growth, I think there may be some differences there, whereas
14 where you have the freestanding, their whole business is on
15 the IRF side, and so they may have more emphasis of
16 controlling what has happened with the cost growth there,
17 too, may be another factor contributing to the difference in
18 the margins, as well.

19 MR. BUTLER: Yeah. You will also notice in
20 Chapter 2, though, that -- and I realize the risk adjusted
21 severity by tiers looks like it's the same across the
22 hospital-based and the freestanding, yet the mix by

1 diagnosis has changed so that the hospital-baseds are
2 treating a lower percentage of orthopedics than the
3 freestanding now and a greater percentage of the strokes.
4 It just makes me wary a little bit. So --

5 MR. LISK: Just to say, the other thing that could
6 be happening is because the person is in that hospital, it
7 may be easier to transfer that patient a little bit earlier
8 than when it goes to freestanding, so there could be
9 something there, but we'd have to do more investigating on
10 that.

11 MR. BUTLER: So I've got some biases for round
12 two, and this is a real dilemma because these are such high
13 margins, you know. What do you do with the hospital-based?

14 So, in general, Medicare as a percentage -- in
15 some of these sectors, Medicare is almost the only payer.
16 Here, I don't know what it is, whether it's -- you know, for
17 ourselves, it might be, like, 60 percent of the business is
18 Medicare, somewhere in that range, and I would expect that --
19 -- would that be typical in the sector, in general?

20 MS. SADOWNIK: [Off microphone.] Yes.

21 MR. BUTLER: Okay. Then we don't probably know a
22 lot about the payer mix of the other 40 percent, and in the

1 freestanding, I suspect you would see some patterns like you
2 do in ambulatory surgery, maybe not as dramatic, but I'm
3 willing to guess that there's a lot less Medicaid and
4 virtually no or very little free care, for example, in the
5 freestandings, but I don't know. That sounds like a comment
6 rather than a question. It's a speculation.

7 DR. MARK MILLER: [Off microphone.] Is it
8 something we can know?

9 MR. LISK: We can look at the Medicaid side of
10 things, yeah.

11 MR. BUTLER: I mean, I just find in our own unit,
12 we're getting swamped where there's no other -- there are no
13 rehab units that will take -- I mean, we take them because
14 we have them, and I suspect that a lot of people wouldn't
15 take some of the non-Medicare lousy payers. And there's
16 nowhere else to go. Okay.

17 MS. SADOWNIK: We can look and we can get back to
18 you on the payer mix, or on the Medicaid.

19 MR. BUTLER: Part of this has to do -- the longer-
20 term impact of if this follows the route that SNFs do over
21 time, where hospitals kind of get out of it, and yet we're
22 left with mostly freestanding for-profits that are not

1 participating in their equal share of treating all patients.
2 We have a different kind of supply issue in the long-term
3 that we ought to be cognizant of.

4 DR. BAICKER: So two quick requests for more
5 information that are probably not on hand right now. One
6 was following up on Rita's questions. I was interested in
7 the difference in quality between the freestanding and
8 hospital-based, particularly because my reading of -- my
9 more naive reading of the table of conditions was that they
10 were pretty balanced. They looked fairly similar in terms
11 of the types of cases they were treating, and it sounded
12 like the case mix within those cases, you have the patient
13 severity was fairly similar across the two, so it would be
14 very interesting, then, to see how the quality compared
15 across the two, given the striking difference in the
16 margins.

17 That also made me think about the sorting of
18 patients across these different types of facilities, as
19 we've talked about, across silos, and you had interesting
20 statistics about the share of each type of patient within
21 IRFs. You know, 20 percent of the IRF patients were for
22 this condition and ten percent for that condition. I'd be

1 interested to know what share of the patients with that
2 condition were treated in IRFs. In other words, how much
3 substitutability is there across sites based on the
4 patient's underlying condition and is it really -- Tom
5 highlighted the sort of funny characteristics of a patient
6 that makes that patient suitable for IRF. They have to have
7 a severe condition but be relatively healthy within that
8 severe condition. It's a funny kind of selection, and I
9 wondered how much possibility there was for sorting across
10 sites based on where those conditions are treated.

11 DR. NERENZ: This may be an extension of Peter's
12 question, but on Slide 11, when you talk about the cost per
13 case difference, it's very striking. What do you know, or
14 what can you tell us about some of the underlying components
15 or drivers of those differences, either the direct or the
16 indirect?

17 MS. SADOWNIK: Besides the economies of scale
18 factors?

19 DR. NERENZ: Well, that's clearly one.

20 MS. SADOWNIK: Yeah.

21 DR. NERENZ: It may also be that there's some cost
22 allocation issues going on in the hospital-based that play

1 into this in some way, economies of scale. But I guess I'd
2 still want to know, what does economy of scale mean exactly
3 in this particular setting, or is it just driven by the
4 occupancy rate? I'm just curious, how should we interpret
5 that difference?

6 MR. LISK: There is, in terms of for the IRF
7 industry, when you think about -- the economies of scale
8 probably is actually a big factor here in terms of -- even
9 incrementally in terms of how you design a unit, and so from
10 what I've heard from some research, one of the firms said
11 basically that you have to have lots of 22 beds, is
12 basically what is an efficient way. So 22, then 44. So,
13 basically, 20, 40, 60. And a lot of the hospitals, you
14 know, if you're at 15, you're not going to be that
15 efficient, so you're going to have both higher direct costs
16 and higher indirect costs because of that.

17 The indirect cost share, in terms of the overhead
18 cost share, actually is lower in hospitals than compared to
19 the freestanding hospital. So in terms of that extra cost
20 allocation, which we may actually see on the home health
21 side, where we see higher indirect costs on home health
22 hospitals, we don't see that in the IRF side. Now, the

1 actual indirect cost per case is actually higher, but it is
2 likely a function of the size of the unit and the economies
3 of scale.

4 If you look at the hospital-based that are 60-bed
5 units, they actually have pretty good margins. They're not
6 as high as the freestanding. But, again, I think there's
7 some of that just -- some of that higher margin in the
8 freestanding may be because of their focused facilities, so
9 they're able to be just more efficient and you have a chain
10 that is focused with half of those freestanding -- one chain
11 has half of those freestanding. And so they are probably
12 just also corporately efficient, as well, which may be a
13 reason for those high margins and the greater efficiency
14 there. It's another speculation there, but that's how I
15 interpret some of the data there.

16 DR. SAMITT: So two quick information requests.
17 One should be easier than the other.

18 Similar to Alice's question on Slide 10, I'd be
19 interested in a four-quadrant analysis looking at the for-
20 profits that are freestanding versus hospital and the not-
21 for-profits that are freestanding versus hospital. Mostly,
22 I'm interested in understanding, are there freestanding

1 institutions that have profit margins up in the 20 percent
2 range that are not-for-profit? So is there anything to
3 learn in that space? I think it would be interesting to
4 have that analysis.

5 The second, which is probably harder, is I'm
6 wondering if there's any data to indicate what we would
7 expect -- would we expect to see a change in utilization of
8 IRFs as a result of readmission penalties to hospitals and
9 whether we're beginning to see that. What you could imagine
10 is that we may see a tendency to shift to greater
11 utilization of IRFs for fear of readmissions versus SNFs or
12 home care, and it may be too soon to really get some kind of
13 indication, but I'd be interested in seeing if anything is
14 available.

15 MR. LISK: That's an interesting question, because
16 I kind of wonder about the increase in the IRF use just
17 recently, from 2010 to 2011, where you're seeing more focus
18 on hospitals in 2011 dealing with the readmission policy. I
19 don't know whether that might be, but that's an interesting
20 --

21 MR. GEORGE MILLER: Yes. If I recall, I'm not
22 sure, but I'm not sure the readmission penalties are on the

1 three modalities that would lend to an IRF. I don't think
2 so, but it would be good to find out. Yeah.

3 MR. HACKBARTH: The readmission penalties are on
4 cardiac --

5 MR. GEORGE MILLER: Cardiac, right --

6 MR. HACKBARTH: -- and CHF --

7 MR. GEORGE MILLER: -- congestive heart failure.
8 Those normally wouldn't go to an IRF, yeah.

9 MR. HACKBARTH: Yeah.

10 MR. GEORGE MILLER: I don't think so, but --

11 MR. LISK: I mean, there's some of those --

12 MR. GEORGE MILLER: -- still a good question.

13 MR. LISK: Some of those patients might, but --

14 MR. GEORGE MILLER: Right. Right.

15 MR. LISK: -- but there's some overall, hospital
16 behavior overall --

17 MR. GEORGE MILLER: Yeah.

18 MR. LISK: -- that may extend beyond those
19 conditions to --

20 MR. GEORGE MILLER: It's still a good question to
21 ask in the race, but a couple things I'd like to focus on.

22 One, demographically, I was somewhat surprised

1 that the Hispanic population was so low in the reading
2 material, four percent versus eight and growing in the
3 population. Is there a reason for that? Have you been able
4 to tease out why that is the case? It was in the reading
5 materials.

6 MS. SADOWNIK: Right, why the Hispanic population
7 was lower --

8 MR. GEORGE MILLER: Yes.

9 MS. SADOWNIK: -- at IRFs than in the general
10 population?

11 MR. GEORGE MILLER: Yeah. Yeah. The others
12 seemed to be mirroring the general population.

13 MS. SADOWNIK: Yeah. I don't have any insight
14 into that right now. I can -- we can think about that.
15 It's not -- I believe it's not unique to IRFs compared with
16 -- I believe SNFs actually have a similar trend, so --

17 MR. GEORGE MILLER: Yeah. Interesting. But the
18 other question has to be -- excuse me, is, for me -- has to
19 be interesting on the map you put in the reading material,
20 which I thought was fantastic. But I was surprised with the
21 circles of ten or more IRFs and their distribution across
22 the United States. At least in my mind, it is surprising

1 where they were, and particularly the dots in -- I was
2 surprised how many are in Louisiana, as an example. It's an
3 interesting place to have a lot of IRFs.

4 I guess my question is, is the industry ripe for
5 consolidation? Would it mean that we may see consolidation
6 there in the future? It would seem to me that that would
7 make some sense, especially with some of the largest chains.
8 But the map doesn't seem to indicate that, so I'm not sure
9 what to draw there, but it's just interesting. I don't know
10 if you've done any work or research of why they are where
11 they are located, what drives the number of IRFs in some
12 interesting places and not in some other places, where you
13 see large populations, large rural areas, but you don't have
14 that type of consolidation. So what is it about IRFs in
15 some of these places, if you've been able to figure anything
16 out? What drives that? Again, particularly, I'm surprised
17 at some of the dots in Southern communities that have ten or
18 more. Any feel for that? Any understanding for that?

19 DR. MARK MILLER: I mean, that is also something
20 that we can come back to you on. I'd be surprised if we
21 knew off the top of our head. Remember, though, with
22 Louisiana, we find this pattern repeatedly, LTCHs --

1 MR. GEORGE MILLER: I know.

2 DR. MARK MILLER: And so there is definitely
3 something going on down --

4 MR. GEORGE MILLER: But isn't that kind of a
5 signal --

6 DR. MARK MILLER: An issue? Yes.

7 MR. GEORGE MILLER: An issue, yeah. A red flag.

8 DR. MARK MILLER: And I think you may have raised
9 that red flag yesterday, and I think you were right then
10 when you raised it as well. And so we can kind of put the
11 same microscope that you raise yesterday on this and see if
12 we can come up with anything here.

13 MR. GEORGE MILLER: Yeah. And then, finally, like
14 Peter and Craig, I'd like to see the margins free-standing -
15 - excuse me -- the margins for hospital-based as it relates
16 to those that are free-standing and then those -- excuse me
17 -- hospital-based that are managed by a for-profit entity
18 versus those operated by the hospital and see if there's a
19 difference in margins there.

20 Thank you.

21 DR. HALL: Could we look at page 8 again, the
22 quality-of-care slide? I just wanted to check out some math

1 here for a minute. Toward the end of that, the last two
2 columns, the discharge to acute-care hospital and then
3 hospital readmission after 30 days, those are not -- they're
4 separate numbers. Does that really mean that within 30
5 days, 22 percent of people admitted to an IRF will return to
6 a hospital? So we have 10.3 percent that go back to the
7 hospital, and then those sent to the community, within 30
8 days 12 percent. So almost one-quarter of all patients that
9 go to an IRF end up back to a hospital. That surprised me.
10 That's a really very high number.

11 And sort of the flip side of what Craig was
12 talking about, if there is any strategy of acute hospitals
13 to use IRFs as kind of an escape valve for discharging
14 patients to reduce length of stay in the acute-care
15 hospital, this is kind of a fool's game because --

16 MR. GEORGE MILLER: Yeah.

17 DR. HALL: -- a lot of them are going to come
18 back. And I notice only 5 percent are cardiac diagnoses, so
19 right now the readmission penalty wouldn't hit them, but it
20 probably will eventually.

21 Is there any kind of benchmark here that says what
22 should that number be like? Is there enough, a small cadre

1 of these institutions or of IRFs that don't have these kinds
2 of return numbers? You know, whether they're the most
3 efficient or whatever.

4 MS. SADOWNIK: Yeah, we can look at the
5 distribution of performance.

6 MR. HACKBARTH: You used the expression, Bill,
7 "it's a fool's game." It's a fool's game from a Medicare
8 perspective.

9 DR. HALL: You bet.

10 MR. HACKBARTH: But from the perspective of the
11 hospital --

12 DR. HALL: Right.

13 MR. HACKBARTH: You get a readmission, and you get
14 the additional revenue associated with that. You shorten
15 the length of stay on your initial readmission; you benefit
16 from that. And so, you know, under the existing payment
17 rules, this looks like a win-win from a provider
18 perspective.

19 DR. HALL: Right. And Alice's comment about if
20 you're going to do double knees, just send them to the IRF
21 and then come back. It's a good thing we don't have four
22 legs instead of two, right?

1 [Laughter.]

2 MR. HACKBARTH: Right.

3 DR. COOMBS: What I was going to say is that
4 discharge to acute-care hospitals is not always a bad thing.
5 It might be that someone says I want you to go here, get
6 yourself together, and get you all spruced up, and then come
7 back for whatever procedure you need.

8 MR. LISK: That is the sometimes the case. And
9 then when you're talking about the cardiac stuff, there are
10 some IRFs that -- even though doing it within the compliance
11 threshold, there are some IRFs that kind of specialize in
12 some cardiac rehab type of stuff, so they have a higher
13 share, so there's some kind of unevenness in that, but
14 they're doing it within the compliance threshold type of
15 thing, too.

16 DR. NAYLOR: So I really like the way that this
17 chapter has uncovered many, many opportunities to take a
18 look at what's happening here and relative to what's
19 happening in alternative SNFs and home health. So I'm
20 wondering, in addition to the great ideas in terms of data,
21 especially since there has been such a dramatic change in
22 case mix to patients more with brain injuries and stroke and

1 so on from when this started and with the threshold rule, if
2 we could do a little bit longer look at this rather than a
3 point in time one year, changes in FIMs, et cetera, we could
4 have a little bit of a trend data that could help us look
5 both within and across settings, as Mike has suggested, but
6 also is there a way to relate this -- and hospital-based
7 versus free-standing. But is there a way to relate this to
8 -- you described decreasing compliance with a 60-percent
9 threshold. Is that right?

10 MS. SADOWNIK: A decrease in compliance with a 60-
11 percent threshold?

12 DR. NAYLOR: So maybe I misunderstood. It said,
13 "The rate of compliance with respect to the 60-percent
14 threshold has been decreasing."

15 MS. SADOWNIK: Oh. Sure.

16 DR. NAYLOR: And I just wanted to know whether or
17 not any of these outcomes might be connected with rate of
18 compliance with the threshold.

19 MS. SADOWNIK: Yeah.

20 DR. NAYLOR: [off microphone].

21 MS. SADOWNIK: Right. It's -- you know, I think
22 in recent years, it's been -- you know, it has been a

1 decrease but very slightly, of course. So --

2 DR. NAYLOR: So it's not a big -- I'm sorry. It's
3 not a big issue then.

4 MS. SADOWNIK: I think -- right. You know, and
5 certainly once -- you know, looking from 2010 to 2011, from
6 61.6 to 61.2. So I think, you know, there's much more
7 instability when the -- you know, in earlier years when the
8 -- you know, when regulations were changing and enforcement
9 was changing. But, you know, in a more recent time window,
10 the differences have been pretty small.

11 DR. NAYLOR: So I think the trend a couple years
12 in looking at this would be great rather than a snapshot,
13 single snapshot. Thanks.

14 DR. REDBERG: Can I --

15 DR. HOADLEY: Yeah, my questions have mostly been
16 hit on the geographic sort of distribution questions.
17 Looking at the map, sort of going the opposite direction
18 that George was talking about, you know, it's pretty well
19 covered, it looks like, in your comment that they're in
20 every state, but I'm wondering are there some markets that
21 really have none or very little presence of these
22 facilities. But then maybe more importantly, and it goes

1 to, again, a question that has come up, the differential
2 distribution of the hospital-based and the free-standing,
3 you know, would the map look very different if we looked at
4 the hospital-based only and the free-standing only,
5 including the question that a couple people have already
6 raised of how often are there markets that are all one or
7 all the other. I think just understanding a lot of that
8 dynamic would be really helpful.

9 MR. HACKBARTH: Okay. We are now 10 minutes over
10 what we had allocated for this whole session, so on Round 2
11 I'd ask people to keep that in mind. I don't want to
12 discourage important comments, but if we could move as
13 quickly as possible, that would be good.

14 As usual, in Round 2 I'd like you to give us an
15 indication of where you stand on the draft recommendation,
16 whether you support it, if not, what you would like to see
17 changed.

18 MR. ARMSTRONG: In general, the issue I have is
19 that we're paying a real premium for IRF services, and it's
20 not clear we're getting our money's worth relative to the
21 other alternative post-acute services. But that's not an
22 issue we can resolve through this decision. Given the

1 margins and other points we've made, I support the direction
2 that you're going in. It may be a little generous.

3 DR. REDBERG: I agree. Obviously, I think we're
4 all concerned that \$17,000 -- I mean, if it was going for
5 sicker patients and better improvements -- so I do have
6 concerns, and I'm sure we'll see more about it.

7 I support the Chairman's draft recommendation for
8 this, although I could go lower.

9 MR. HACKBARTH: I would like the record to show
10 the use of "generous" when applied to me. It's not one that
11 I'm used to hearing.

12 [Laughter.]

13 MR. HACKBARTH: Perhaps we could put that in bold
14 in the transcript.

15 [Laughter.]

16 DR. COOMBS: I think there's so many questions
17 that have come up, I have in the back of my mind the
18 possibility that there might be margins in great excess when
19 you break down the specific groups, and I'm just curious as
20 to that result.

21 With all this being said, I support the
22 recommendations of the Chair.

1 DR. DEAN: Yeah, I support the recommendation. I
2 just was looking. This probably should have been in Round
3 1, but on Table 12 in the mailing material, it's really
4 striking that the margins for free-standing have been
5 relatively stable for a long time, and there has been a --
6 go back to '04. The hospital-based had a margin of 12
7 percent, and it has steadily decreased until it was negative
8 in '11. Do we have any idea what was the reason for that
9 trend? It's a striking trend compared to whereas the free-
10 standing were pretty stable.

11 DR. MARK MILLER: This is the question that came
12 up, I think, over here, and we'll put some thought into
13 that.

14 DR. DEAN: Okay. Anyway, generally I support it.

15 MS. UCCELLO: Yeah, I agree, and like some of the
16 others, depending on what comes out, could be convinced to
17 go lower.

18 MR. KUHN: I support the recommendation.

19 DR. CHERNEW: I support the recommendation.

20 MR. BUTLER: I support, but just a short
21 editorial. In the absence of -- this is Exhibit A and LTCHs
22 will be Exhibit B of why we need to look at the post-acute

1 options as a collective set of tools. And the one thing I
2 would highlight is that I've brought up before that every
3 hospital now has their medical spending per beneficiary data
4 in hand. This includes the three days prior and 30 days
5 post-acute stay data that is scheduled to be part of
6 value-based purchasing in 2015. If you look at this data,
7 it shows that approximately 30 percent of the episode
8 spending in the aggregate is in the post-acute. And to the
9 extent that hospitals now will be subjective in a value-
10 based purchasing for those options, it will begin to look --
11 in addition to ACOs and Medicare Advantage plans, it will
12 become much more obvious, the cost of these alternatives and
13 whether or not they are better than, for example, home care,
14 which tends to be the least expensive, but that doesn't mean
15 it ought to be the only option in post-acute care either.

16 DR. BAICKER: I support the recommendation and
17 second the strong sentiment that we need to harmonize across
18 these post-acute care settings.

19 DR. NERENZ: I generally support. I just still am
20 struck by this difference in the cost structure between the
21 two types of settings, and I could imagine us being at least
22 receptive to an argument from the hospital-based side that

1 these facilities were providing some sort of essential
2 access function, perhaps being the only source in certain
3 areas, and that the cost structure was simply inevitable and
4 a result of things that could be defended. I have not hear
5 such an argument, and you have not given us such an argument
6 to consider. So in the absence of such an argument, I'm in
7 support.

8 DR. SAMITT: I support the recommendation, and I
9 thought also about the notion of whether we should go lower,
10 although I'm a bit concerned about hospital IRF margins,
11 especially in the setting where there isn't a readily
12 available large nonprofit. And so I think we just have to
13 be cautious.

14 This is another example of kind of the danger of
15 viewing payment to IRFs as a silo from the rest of the
16 system, especially as it pertains to expanding diagnoses for
17 hospital readmission penalties, we may see the utilization
18 of IRFs inappropriately increase if the referring hospitals
19 were accountable for the cost implications and quality
20 outcomes of where they refer post-acutely to, then I think
21 that we would address those concerns. So it goes back to,
22 again, the notion of needing to bundle and not just view

1 other post-acute options separate from each other, but also
2 look further upstream to the physicians and the hospitals
3 that are referring them to those institutions.

4 MR. GEORGE MILLER: Yes, I'm going to be
5 consistent with my statements from yesterday. I'm a little
6 bit concerned that the Hispanic population is not equally
7 represented. In general, I would support the
8 recommendations, or lower, but I do have, like both Peter
9 and David expressed a concern, the difference between
10 hospital-based versus for-profit where in the areas of the
11 country that is the only source for these patients.
12 Otherwise, I would feel strongly that we should probably
13 lower your recommendation -- or the recommendation, lower
14 it, because I must stay consistent that the Medicare program
15 should be available to everybody, and if it's markedly
16 different for all beneficiaries, no matter where they are
17 demographically, I have a problem.

18 DR. HALL: I'm also in support of the
19 recommendations. I'm a firm believer in the advisability,
20 even necessity of some form of rehabilitative and
21 restorative services for Medicare patients after
22 hospitalization. I don't think this is going to be the

1 long-term answer, though, this high-margin service that
2 serves a relatively small proportion of Medicare patients by
3 virtue of the constrictions put on admissions.

4 So I think we've got a lot of work to do, but I
5 think we should approve this as it is for now.

6 DR. NAYLOR: I also support the recommendations
7 and echo comments of colleagues about the real opportunity
8 here to urgently develop a rational post-acute system that
9 aligns with people's needs and gets us to more efficient and
10 effective care for them and for the program.

11 DR. HOADLEY: I also support the recommendation
12 and, like others, echo what Mary just said and others have
13 said, but also the notion that depending on what we learn
14 about some of these side questions, could even be a lower
15 update than in the recommendation.

16 MR. HACKBARTH: Okay. I think this has been a
17 good discussion, and we've identified some important issues,
18 a few of which we may be able to answer the questions before
19 January, others that won't be possible. And, you know, that
20 influences my thinking about how quickly to move here. It
21 may be that over time a reduction in the rates is
22 appropriate, but I think we need to move with some care in

1 that regard.

2 Just one other thought. At the end of our session
3 yesterday I said from my perspective one of the advantages
4 of moving towards bigger bundles is that it facilitates the
5 flow of resources to where they can be most effectively
6 deployed. Then I combine that thought with looking at
7 individual silos and trying to push down the rates and
8 eliminate -- reduce the resources available. Those two
9 things may be at odds. You know, maybe what we want to do
10 is have the resources, just have them deployed elsewhere in
11 the system in a way that they would more effectively
12 contribute to better care for patients. If we sort of
13 squeeze them out silo by silo, then they're gone, and there
14 isn't that opportunity to redeploy in more effective ways.

15 So for me, that's just one more argument in favor
16 of moving quickly towards new payment models and getting out
17 of this silo-based approach.

18 Thank you, Sara and Craig.

19 Now we move on to long-term care hospitals.

20 MS. KELLEY: Good morning.

21 Some patients with medically complex problems need
22 hospital-level care for extended periods of time. In the

1 literature, these patients are described as the chronically,
2 critically ill, or CCI. Nationwide, most CCI patients are
3 treated in acute care hospitals, but a growing number are
4 treated in long-term care hospitals.

5 As you know, the Commission has called for the
6 development of criteria to define the CCI patients that are
7 treated in LTCHs and other similar settings, such as acute
8 care hospital step-down units and specialized SNFs. In the
9 coming months, I hope to bring you some more information and
10 analyses on criteria for LTCHs, but today I'll be focusing
11 on the analysis of payment adequacy for this setting.

12 First, just a little bit of background
13 information. To qualify as an LTCH under Medicare, a
14 facility must meet Medicare's conditions of participation
15 for acute care hospitals and have an average Medicare length
16 of stay of greater than 25 days. Due to these long stays
17 and the level of care provided, care in LTCHs is expensive,
18 averaging more than \$38,000 per case in 2011. Medicare pays
19 LTCHs on a per-discharge PPS, and it uses the same MS-DRGs
20 as the acute care hospital PPS but with different weights.
21 Payments can be adjusted upwards for cases with
22 extraordinarily high costs and downwards for short-stay

1 outliers.

2 Following implementation of the PPS in fiscal year
3 2003, Medicare spending for LTCH services grew rapidly, as
4 you can see here, climbing an average of 29 percent per year
5 between 2003 and 2005. This growth prompted concerns about
6 the demand for LTCH care, patient selection and the possible
7 unbundling of services covered by the acute care PPS. And,
8 as a result, CMS implemented a number of regulations
9 addressing those concerns.

10 Following that, between 2005 and 2008, growth in
11 spending slowed to less than 1 percent per year.

12 After Congress rolled back, or delayed,
13 implementation of some of these regulations, spending for
14 LTCH services began to climb again, rising 12 percent
15 between 2008 and 2010.

16 Spending growth slowed somewhat between 2010 and
17 2011 due mostly to a reduction in the payment rate.
18 Spending totaled \$5.4 billion in 2011.

19 Our first consideration in our analysis of payment
20 adequacy is access to care. We have no direct indicators of
21 beneficiaries' access to LTCH services. So we focused on
22 capacity and use, but it's important to keep in mind that

1 this product is not well defined and it's often not clear
2 what Medicare is purchasing with its higher LTCH payments.

3 There are no established criteria, as I said,
4 admission to an LTCH. So it's not clear whether, or which,
5 patients treated there require this level of care.

6 And, remember that many Medicare beneficiaries
7 live in areas where there are no LTCHs and so receive
8 similar services in other facilities.

9 Research has shown that outcomes for most
10 medically complex beneficiaries who receive care in LTCHs
11 are no better than for those for similar patients who don't
12 have an LTCH stay.

13 To gauge access to services, we first looked at
14 capacity. This slide shows growth in the number of LTCHs
15 nationwide, in green -- it might be a little hard to see.
16 Sorry about that -- and the number of beds in blue.

17 From the late 90s until 2005, the number of LTCHs
18 more than doubled, and you can see the tail end of that
19 growth here.

20 Beginning in 2005, as CMS implemented those
21 payment regulations that I mentioned, facility growth slowed
22 markedly. Although Congress temporarily eased some of those

1 regulations, facility growth has remained low due to a
2 moratorium on new facilities that's been in place for the
3 last five year. That moratorium is due to expire at the end
4 of this year, 2012.

5 In spite of the moratorium, we continue to see
6 growth in the number of LTCH cases per fee-for-service
7 beneficiary. That number rose 2.8 percent between 2010 and
8 2011, suggesting that access to care increased during the
9 period.

10 Turning now to quality, LTCHs just began
11 submitting quality data to CMS this past October. CMS is
12 required to implement an LTCH pay-for-reporting program
13 beginning in fiscal year 2014.

14 To start, LTCH quality will be measured on three
15 dimensions that I've listed here: catheter-associated UTIs,
16 bloodstream infections due to central lines and new, or
17 worsened, pressure ulcers. Until these data are available
18 for analysis, we continue to rely on claims data to examine
19 trends in in-facility mortality, mortality within 30 days of
20 discharge and readmission to acute care to assess gross
21 changes in quality

22 In 2011, these rates were stable or declining for most of

1 the common LTCH diagnoses.

2 Access to capital is the next step in our payment
3 adequacy analysis, and access to capital allows LTCHs to
4 maintain and modernize their facilities. If LTCHs were
5 unable to access capital, it might reflect problems with the
6 adequacy of Medicare payments since Medicare accounts for
7 about half of LTCH total revenues in aggregate. However,
8 for the past few years, the availability of capital says
9 more about uncertainty regarding changes to regulations and
10 legislation governing LTCHs than it does about current
11 reimbursement rates.

12 Since 2007, the moratorium on new beds and
13 facilities imposed by MMSEA has reduced opportunities for
14 expansion and the need for capital. With the moratorium
15 expiring, it seems reasonable to expect that LTCHs are
16 poised to expand existing capacity or open new facilities,
17 but market analysts that we spoke to are doubtful that this
18 is the case, at least in the near term. CMS's continued
19 scrutiny of Medicare spending on LTCH care and uncertainty
20 about possible congressional action may be prompting some
21 caution.

22 As an example, analysts pointed out that the

1 moratorium does not prevent LTCH companies from expanding
2 their operations through mergers with, or acquisitions of,
3 other existing LTCH, but no such transactions have happened
4 in the last year. One major LTCH chain which controls about
5 a quarter of all LTCHs has continued to acquire other post-
6 acute care providers, which suggests it is able to access
7 needed capital. But smaller chains and non-profits might
8 not have the same level of access.

9 So how have LTCHs' per-case payments compared to
10 per-case costs. In the first years of the PPS, LTCHs
11 appeared to be very responsive to changes in payment,
12 adjusting their costs per case as payments per case changed.
13 Payment per case increased rapidly after the PPS was
14 implemented, climbing an average 17 percent per year from
15 2003 to 2005. Cost per case also increased rapidly during
16 this period albeit at a somewhat slower pace.

17 Between 2005 and 2008, as changes were made to
18 LTCH payment policies, growth in payments per case was
19 outpaced by growth in costs. During that period, growth in
20 payments per case slowed to an average of 1.5 percent per
21 year.

22 After the Congress delayed the implementation of

1 some of CMS's regulations and CMS implemented a revised
2 classification system, growth in payments per case began to
3 pick up again.

4 Between 2008 and 2009, growth in payments per case
5 was 5 percent, more than twice as much as the growth in
6 costs.

7 Payment growth slowed after that to an average of
8 1.6 percent per year between 2009 and 2011. Cost growth has
9 been held under 1 percent per year during that period.

10 Margins have, of course, tracked the trends you
11 see here, rising rapidly after the implementation of the PPS
12 from a bit below zero to a peak of 12 percent in 2005. At
13 that point, margins began to fall until 2008 when they began
14 to increase again.

15 And this next slide shows 2011 margins for all
16 LTCHs combined and for different LTCH groups as well as the
17 share that each represents of total providers and total
18 cases. As you can see in the top row, the aggregate
19 Medicare margin for 2011 was 6.9 percent. There is wide
20 spread in the margins, similar to what you've seen in other
21 settings, with the bottom quarter of LTCHs have an average
22 margin of minus 9.2 percent and the top quarter having an

1 average margin of 20.6 percent. However, our analysis found
2 that margins increased between 2010 and 2011 for all
3 categories of LTCHs.

4 There is a substantial ownership effect, as you
5 can see. Three-quarters of LTCHs are for-profit, and they
6 posted an average margin of 8.5 percent in 2011. The margin
7 for non-profits, as you can see, is much lower. One reason
8 for this difference may be that non-profits tend to be
9 smaller than for-profits and so they may have fewer
10 economies of scale.

11 We looked more closely at the characteristics of
12 established LTCHs with the highest and lowest margins. This
13 slide compares LTCHs in the top quartile for 2011 margins
14 with those in the bottom quartile. As you can see in the
15 top line, low-margin LTCHs had standardized costs per
16 discharge that were 36 percent higher than high-margin
17 LTCHs, and this appears to be the primary driver of
18 differences in financial performance between these two
19 groups.

20 High-margin LTCHs tend to be larger, as I said,
21 and to have higher occupancy rates, so they may benefit more
22 from economies of scale. And high-margin LTCHs have far

1 fewer high-cost outlier cases and lower outlier payments,
2 and they have a lower share of short-stay cases. Finally,
3 high-margin LTCHs are much more likely to be for-profit.

4 To estimate 2013 margins, we modeled the impact of
5 several policy changes. We included the payment updates for
6 2012 and 2013, and for both years this update was adjusted
7 by a PPACA-mandated reduction. We also included regulatory
8 changes in 2013 that we expect will reduce payments.

9 First, CMS is taking a budget neutrality
10 adjustment over three years beginning in 2013. This
11 adjustment is intended to correct for CMS's underestimate of
12 how much LTCH spending would increase in the first year of
13 the PPS.

14 CMS has also made changes to the short-stay
15 outlier policy that we also expect will reduce payments.

16 All together, we estimate that these effects will
17 result in somewhat greater growth in provider costs than in
18 provider payments, and we've project a margin of 5.9 percent
19 in 2013.

20 So, to sum up our update analysis, the moratorium
21 has stabilized the supply of facilities and beds, but we
22 continue to see growth in the volume of services.

1 We have little information about quality in LTCHs,
2 but mortality and readmission rates appear to be stable.

3 The moratorium has limited opportunities for
4 expansion. So access to capital is difficult for us to
5 assess and may not be a particularly meaningful measure at
6 this time.

7 Our projected margin for 2013 is 5.9 percent, and
8 our projected decrease in the aggregate margin is consistent
9 with expected effects of congressional-mandated and
10 regulatory reductions in payment updates.

11 We make our recommendation to the Secretary
12 because there's no legislated update to the LTCH PPS. The
13 Chairman's draft recommendation is that the Secretary should
14 eliminate the update to payment rates for long-term care
15 hospitals for rate year 2014.

16 CMS historically has used the market basket as a
17 starting point for establishing updates to LTCH payments.
18 Thus, eliminating the update for 2013 will produce savings
19 relative to the expected regulatory update even assuming
20 PPACA-mandated reductions. We don't anticipate any adverse
21 impact on beneficiaries or on providers' willingness and
22 ability to care for patients.

1 So, with that, I will conclude and turn it over to
2 you for discussion. I'm happy to answer any questions.

3 MR. HACKBARTH: Okay. Thank you, Dana.

4 Would you put up slide 9, please?

5 So would you remind us what payment system was in
6 effect prior to 2003?

7 MS. KELLEY: Sure. Before 2003, LTCHs were paid
8 under the TEFRA rules, which essentially was a cost-based
9 payment system with limits on reimbursement. Facility-
10 specific limits, rather.

11 MR. HACKBARTH: So, for anybody who believes that
12 moving to prospective payment is, by definition, a step in
13 the right direction to move toward efficiency, it seems to
14 me this graph should at least raise some questions in their
15 mind.

16 Every year, you know, we look at this. In fact,
17 if you do a similar graph for home health, as I recall, you
18 see a very similar picture -- move to prospective payment;
19 both payments and costs have increased.

20 So a payment method alone is not necessarily going
21 to lead to lower costs.

22 That's for the new commissioners. This graph is

1 one that Nancy Kane, a former commissioner, used to comment
2 every year, as sort of a sobering reminder.

3 Jack, do you want to lead off with clarifying
4 questions?

5 DR. HOADLEY: Sure. I guess I'll go to geography
6 again.

7 And, obviously, this is a sector where the
8 geographic distribution, as you pointed out, is not uniform
9 around the country. There's obviously not been a lot of
10 growth, but has the growth modified that as the -- to the
11 extent that there have been new facilities, have they gone
12 into areas that already have facilities, or have they gone
13 into areas without?

14 MS. KELLEY: Almost without exception, they go
15 into areas where there are already are LTCHs, yes.

16 DR. HOADLEY: Okay. And, you know, you talked
17 about the fact that where there aren't facilities people do
18 find -- and I know from my own work, you know, people find
19 their way into SNFs and other sorts of things. I mean in
20 some ways it's an interesting, you know, case study of
21 substitutability.

22 I guess I also was wondering about how often there

1 are multiple facilities competing in a market and whether
2 there's any relationship there to the margins that we see.

3 MS. KELLEY: Very often, there are LTCHs competing
4 within a market.

5 I have not looked at margins on that metric. That
6 could be interesting to do. I will see if I can do
7 something like that.

8 DR. HOADLEY: Okay. Good. Thank you.

9 DR. NAYLOR: Thank you for a great report.

10 In the top MS-DRGs that are now the focus, there's
11 been a pretty substantial change in them in recent years,
12 meaning a 49 percent change in the number that are now
13 coming into these LTCHs with respiratory failure and a
14 pretty substantial reduction in others.

15 And I'm wondering if you could comment on the
16 changing face of the people served in LTCHs. Or, does this
17 have to do with the MS-DRG system's changes?

18 MS. KELLEY: I don't think it's due to the MS-DRG
19 changes. The literature would suggest that we -- our
20 technology has gotten to a point where we are saving many
21 more people than we used to save in the past and that coming
22 out of hospitals there are many more patients who are

1 ventilator-dependent or who have other respiratory issues
2 that require a high level of care. And, certainly, the
3 discharges from acute care hospitals of patients who require
4 prolonged mechanical ventilation has increased markedly.
5 And I think that's some of what you're seeing reflected
6 here.

7 I also think that over time the -- I think several
8 years ago there used to be more overlap in the patients that
9 were in -- nationwide, in the patients that were in SNFs and
10 those that were in LTCHs.

11 But I think, as we have pointed out for many
12 years, payment for certain medically complex patients in
13 SNFs was probably not what it should be, or relative to
14 payment for other types of patients but did not produce the
15 same kinds of margins, and many SNFs became less and less
16 interested in taking these patients. They can back up in
17 acute care hospitals, and I think in some areas LTCHs have
18 stepped in to sort of take those patients in.

19 DR. HALL: Along the same lines, table 3, which
20 has the top 25 diagnoses -- you know, the respiratory
21 diagnoses just dominate this list all the way through. It's
22 probably 75 percent of what goes on here. Do we know

1 anything about how that relates to the difference between
2 high and low-margin facilities?

3 Is that a --

4 MS. KELLEY: There is -- you know, the respiratory
5 diagnoses are so prominent here that basically all
6 facilities - all LTCHs take care of -- a large share of
7 their patients fall into these respiratory diagnoses.

8 Generally, the facilities with higher case mix do
9 have higher margins. That's a broad statement but generally
10 true.

11 And so -- and some of the respiratory diagnoses
12 are among the higher weighted DRGs.

13 DR. HALL: Thank you. I'll come to that.

14 MR. GEORGE MILLER: Same as Jack mentioned on the
15 geographic distribution -- and I'll make my same comment
16 about Louisiana again.

17 My question, more specifically concerning the
18 outcomes -- do we have an understanding if patients with the
19 same diagnoses, as was just mentioned about respiratory,
20 have different outcomes going to the LTCH versus going to
21 other places, particularly in those areas where there are
22 few, or no, LTCHs?

1 And then, my second question deals with the growth
2 area where all the growth is specifically where other LTCHs
3 are. Should we consider maybe recommending a moratorium?

4 In my mind, that makes no sense; that's where the
5 growth is -- where there are already LTCHs.

6 MS. KELLEY: Extending the moratorium, you mean?

7 MR. GEORGE MILLER: Yes.

8 MS. KELLEY: Yes. I think that the --

9 MR. GEORGE MILLER: I mean, there must be an
10 exception. They can grow now. I'm saying, how do we --

11 MS. KELLEY: Well, there were exceptions to the
12 moratorium that allowed facilities that were already in the
13 pipeline to continue.

14 MR. GEORGE MILLER: Okay. Oh, I see.

15 MS. KELLEY: And then, the pipeline was sort of
16 broadly defined to include anyone who already had a
17 certificate of need.

18 MR. GEORGE MILLER: I got it. I got it.

19 MS. KELLEY: Which could be several years old.

20 MR. GEORGE MILLER: Sure, sure. I got it.

21 MS. KELLEY: So that's why we continued to see a
22 little bit of growth throughout the moratorium, especially

1 in the early years.

2 MR. GEORGE MILLER: I got it. Okay.

3 MS. KELLEY: But that does seem to have, you know,
4 leveled off as the moratorium went on.

5 Yeah, I think that the real issue there is the
6 certificate of need. In states that have strong certificate
7 of need of limitations, we don't see any growth in those
8 areas.

9 Your first question?

10 MR. GEORGE MILLER: Do you see a difference --

11 MS. KELLEY: Oh, on outcomes.

12 MR. GEORGE MILLER: On outcomes with the same
13 diagnosis, especially with those patients in areas of the
14 country that have no LTCHs or never go to an LTCH versus
15 those that go to an LTCH.

16 MS. KELLEY: There have been a lot of studies over
17 the past several years trying to answer that question.
18 MedPAC did some work back in the early 2000s, and CMS has
19 done a lot of work in this area.

20 And we, in our work -- and other researchers as
21 well -- have not been able to find real differences in
22 outcomes by at least looking in terms of readmissions and

1 mortality rates and sort of gross measures that we had.

2 The care demonstration allowed for the first time
3 to sort of collect all that information about LTCH patients
4 in order to try and compare them more accurately with other
5 patients.

6 And in the care demonstration as well, there was
7 very little difference in outcomes. The only difference
8 that was seen was in hospital readmissions within 30 days of
9 discharge from the acute care hospital.

10 Of course, LTCHs are certified as acute care
11 hospitals. So one would expect that they would be able to
12 handle problems that a SNF or an IRF or a home health agency
13 couldn't handle.

14 It was also found in another study, using the care
15 tool, that 30 days after discharge from the LTCH readmission
16 rates were higher for LTCHs. So -- and that likely speaks
17 to the sickness of the patient population.

18 MR. GEORGE MILLER: Yeah, yeah. And just one
19 final quick question -- what is the average length of stay
20 for an LTCH?

21 I know it's a minimum of 25 days, but what ends up
22 being --

1 MS. KELLEY: The average length of stay is about
2 25 -- 24 days, but it does vary -- shall I show my slide?

3 It does vary by diagnosis.

4 And this is sort of an interesting thing I did.
5 This is the top two diagnoses. 207 is prolonged mechanical
6 ventilation, and 189 is pulmonary edema and respiratory
7 failure. And you can see that there is a wide spread in
8 lengths of stay. The number of cases there is on the
9 vertical axes.

10 MR. GEORGE MILLER: Right.

11 MS. KELLEY: You see that big climb up there. Now
12 you might think that that was 25 days, but it's not, if you
13 look down below.

14 MR. GEORGE MILLER: Yeah, yeah.

15 MS. KELLEY: What that is, is the short-stay
16 outlier threshold.

17 MR. GEORGE MILLER: Oh.

18 MS. KELLEY: So once the case gets past -- every
19 DRG has its own short-stay outlier threshold, of course,
20 based on the average length of stay for the DRG.

21 So once we get past that point, we see it does
22 have a significant impact on discharge.

1 MR. GEORGE MILLER: Thank you.

2 DR. SAMITT: So I have two questions.

3 Going back to -- what slide was that? Eight, I
4 think.

5 As a big believer -- it's the next slide. I'm
6 sorry.

7 MS. KELLEY: Nine?

8 DR. SAMITT: Nine. As a big believer in
9 prospective payment, I was very surprised to see this graph.
10 And, I just didn't understand the methodology for payment
11 adjustments between 2003 and 2005, in particular -- a nearly
12 25 percent increase in prospective payment. What was the
13 basis for that back in those years?

14 MS. KELLEY: When the PPS was first implemented,
15 of course, it's based on previous payment. You know, it's
16 based on analysis of what previous payments were and claims
17 data to assess what payments should be in the first year of
18 the PPS.

19 A major problem that we have in moving from cost-
20 based reimbursement to prospective payment -- and I think,
21 as Glenn said, we've seen this in every PPS, including the
22 acute care hospital PPS -- is that when cases are paid on

1 the basis of costs there's not much motivation to code
2 specifically.

3 When you move to a PPS that's based on diagnosis,
4 there's a big change in coding. And we've seen that.
5 Obviously, you've talked about that with the acute care
6 hospital quite a bit in the past.

7 So some of this is simply a big increase in
8 documentation and coding improvements that results in growth
9 in payments and case mix. Some of it is because of the way
10 the TEFRA system operated.

11 Remember, TEFRA was put into place in 1983 as a
12 very short-term fix before PPS -- or 1992, before PPS was
13 implemented for acute care hospitals. And then, it went on
14 for these excluded facilities -- LTCHS, IRFs, psychiatric
15 facilities, et cetera -- much longer than it was intended.

16 And, over time, there were some really perverse
17 incentives under TEFRA that favored -- greatly favored --
18 new facilities and encouraged new facilities to open up,
19 operate at very high cost levels in order to establish a
20 high-cost basis and then, going forward, to ratchet down
21 their costs but keep -- their payments would be based on
22 that initial high-cost basis.

1 So there is a sense that the aggregate payments
2 that were used as a basis to establish what payments should
3 be, in a budget neutral fashion, under the PPS, were
4 probably too big.

5 And so, over time, CMS has tried to -- has made
6 adjustments for documentation and coding improvements.
7 They've made changes to the way they pay for short-stay
8 outliers, which were certainly too generous in the early
9 years of the PPS. And they also made adjustments. They put
10 in something called the 25 Percent Rule for hospitals --
11 LTCHs that operate within acute care hospitals -- that
12 prevented them from admitting more than a certain share of
13 their patients from that one hospital.

14 DR. SAMITT: Great.

15 DR. CHERNEW: I just want to add one thing
16 conceptually.

17 A lot of times when you see graphs like this it's
18 tempting to think that the cost trend is sort of
19 predetermined. If PPS is working, by definition, the
20 incentives would require the institutions to hold the costs
21 down below what their payments are.

22 So all the things that Dana said, I think, are

1 exactly right, but you shouldn't look at a deviation between
2 the actual cost trends and the payment trends as a sign that
3 the payment trends were too high. You might look at
4 something like this and say, oh, the incentives are working.

5 The real question is you'd want to know what would
6 the cost trends have been had they still been paid costs.

7 And that, we don't know.

8 So there are all the things you said, I think,
9 matter exactly, and there's all kinds of coding, and there's
10 base cost things that get messed up. It's our job to think
11 about it in our update stuff. But just because you see this
12 gap doesn't mean evidence that PPS was doing a bad job.

13 MR. HACKBARTH: So it sounds like you're focusing,
14 Mike, on the gap between the blue line and the yellow line.

15 PARTICIPANT: I'm looking at the slope [off
16 microphone].

17 MR. HACKBARTH: The other striking thing is the
18 change in the yellow line with the implementation of PPS.
19 Forget the blue line.

20 DR. CHERNEW: Right [off microphone].

21 DR. BAICKER: So what you'd like to see is the
22 green line that had been forecasted --

1 DR. CHERNEW: Right, right [off microphone].

2 DR. BAICKER: That had been forecasted in 2001,
3 which might or might not have been correct, but would give
4 you a sense of how the curve had potentially bent relative
5 to what you had anticipated it to be.

6 DR. CHERNEW: That's true.

7 DR. MARK MILLER: And the other two lessons I
8 would draw from this. and the second one you guys may agree
9 or disagree with, but keep this in mind because this keeps
10 showing up all over the place. Was the base rate set right
11 for home health? Was it set right for SNF? You know,
12 dialysis just went into PPS. We're starting to see some
13 shifts in the trend, and so we need to keep an eye on this.
14 And this is, of course, a comment that comes up all the
15 time. We're always chasing our tail. This is why we need
16 to get to different payment systems, and that's another
17 lesson to draw to this.

18 I also think you can look at this -- and you guys
19 may disagree with this, but the other thing to keep in mind
20 is where you set your payment may also drive your costs.
21 And so that could be another indication here, although given
22 all the -- there's, you know, the for-profit here, there is

1 a bit of a surprise that it follows it that closely, because
2 the for-profits tend to keep their costs down relative to
3 not-for-profit.

4 MS. KELLEY: But the other -- I'm sorry.

5 DR. SAMITT: That was the basis of my question
6 because I look at this and I presume that the cost line is
7 following -- the green line is following the blue line as
8 opposed to the other way around. And so that's the concern
9 that, you know, perhaps we were overly generous in that
10 methodology, allowing the freedom of cost expenditure in
11 these settings.

12 MS. KELLEY: I think the other thing to keep in
13 mind that might be reflected in the cost line here is that
14 when the LTCH PPS was put into place, we had a large growth
15 in the number of hospitals within hospitals, and their costs
16 we could see were higher, you know, for a number of
17 different reasons. And so some of that may be driving the
18 average cost there, and as now hospitals within hospitals
19 have sort of -- growth has completely halted and, in fact,
20 there have been some closures in hospitals within hospitals.
21 And so that may have caused some of the flattening you see,
22 too.

1 DR. SAMITT: I have one other quick question, and
2 that's on Slide 11. Do you have an understanding of the
3 difference between the high-cost outlier between high margin
4 and low margin? I guess my question is: Is there a patient
5 selection effect here, or what is the reason for this major
6 difference?

7 MS. KELLEY: Several in the industry will tell you
8 there is a case-mix difference here. It's very difficult to
9 sort of get under what's going on here. There is not a big
10 difference in case mix, at least in terms of the DRGs
11 themselves, so there is -- the high-margin LTCHs do tend to
12 take care of the more higher -- of the higher sort of acuity
13 cases, but they either -- you know, for whatever reason,
14 they care for them in a shorter period of time, or they have
15 -- you know, they've selected a less severely ill -- it's
16 hard to say what's going on there.

17 DR. SAMITT: Okay.

18 DR. NERENZ: A couple of quick questions. If you
19 could just toggle quickly between 3, 5, and 6.

20 [Laughter.]

21 DR. SAMITT: Every few seconds or what?

22 DR. NERENZ: You don't have to keep spinning it.

1 There's clearly an inflection point in '05, and it's up on
2 the slides as well. PPS started in '03. The moratorium was
3 very late '07, effectively '08. You've made mention of just
4 changes generically in '05 in that period. What
5 specifically or is there something specifically in '05 that
6 we should think about? Because clearly that year something
7 happened there.

8 MS. KELLEY: Yeah, two things I think are relevant
9 here. First is the 25-percent rule that I mentioned went
10 into effect, and that prohibited -- it limited the share of
11 cases that a hospital within hospital, so an LTCh
12 established within an acute-care hospital, could admit from
13 that one hospital. So prior to 2005, there was a big
14 advantage, I think, to acute-care hospitals having an LTCH
15 in their hospital. After 2005, the advantage of that
16 declined because they couldn't move as many patients to the
17 facility.

18 The other thing that changed about that time was
19 CMS began to ratchet down on what were, I think, clearly
20 overpayments for short-stay outlier patients, and so that,
21 too, I think, reduced -- everything's relative, but it
22 reduced the attractiveness of having an LTCH and anything

1 that sort of reduced the aggregate payment there.

2 DR. NERENZ: Okay. Then if you could just back up
3 one to Slide 4, just for information, we talk about the
4 other settings. What are the other settings? And do we
5 have data that let us know what the distribution of CCI
6 patients is in these other settings?

7 MS. KELLEY: So the other settings that we've
8 typically talked about are the other post-acute care
9 settings, particularly SNFs, especially now that we have the
10 compliance rules for IRFs that really limit -- as we talked
11 about before, it may be a very ill person, but it's
12 certainly not a frail person, if you will, who goes into an
13 IRF. So the other settings that might be comparable to an
14 LTCH are SNFs, but especially acute-care hospitals.

15 DR. NERENZ: That's exactly what I wondered,
16 because it seems like there's both an up and a down option
17 in terms of the acuity of the alternative, and I'm just
18 curious. What do we know about the distribution across
19 those alternatives?

20 MS. KELLEY: Well, I do have a slide that I put
21 here just in case we had a question about this. So this is
22 some work that Julian Pettengill and I have been doing, and

1 this looks at -- so these are discharges from 2010 from
2 acute-care hospitals, and we've got three bars here: one is
3 patients who had less than four days in an ICU or a CCU, the
4 middle one is four to seven days, and the right-hand bar is
5 eight or more. And this shows the discharge destination for
6 these patients.

7 Patients who did are not included here, so the
8 other setting is either they went -- it's basically they
9 went home. Some of them may have gone to home health as
10 well. The red, as you can see, is SNF and IRF. The yellow
11 bar is LTCH, and the blue -- oh, I'm sorry. Died is on
12 there. I'm sorry. Died is in blue.

13 So you can see, you know, there's -- I think this
14 sort of shows the severity of illness aspect of it, but also
15 shows that, you know, patients do go to various different
16 settings.

17 DR. NERENZ: Okay. So the acute hospital as an
18 alternative is part of the green, but it is not all of the
19 green.

20 MS. KELLEY: Well, the acute-care hospital here
21 wouldn't -- this is the discharge destination, right? So --

22 DR. NERENZ: So they have all left.

1 MS. KELLEY: Yeah.

2 DR. NERENZ: But some could stay.

3 MS. KELLEY: Sure. And, in fact, in your eight-
4 plus column, you're likely to have, you know, the longer
5 acute-care hospital stays.

6 DR. MARK MILLER: I think you are asking the right
7 question. I think. Depending on whether you were headed
8 with it. I mean, one of the things I think that we grapple
9 with and what Dana and Julian are thinking about right now
10 is, you know, in the areas where there is not this option,
11 then the hospital deals with it. And so, you know, the
12 equity in the payment system between those two scenarios is
13 something that we're trying to think about. There's kind of
14 the LTCH payment itself, and then, you know, we have to deal
15 with it in silos because of what we have to do this month.
16 But in a broader sense, we're trying to think about how to
17 alter this payment system in such a way that when the
18 hospital is having to deal with this, there is some equity
19 in that sense. So if that's where you're headed, there is
20 some thinking going on.

21 MR. HACKBARTH: Yeah, so there is, as you say,
22 Mark, an equity issue, but there's also -- it seems to me

1 there may be a question of whether it might be a lower-cost
2 option for Medicare to have them stay a little bit longer in
3 an acute-care hospital in a more robust outlier payment to
4 accommodate that as opposed to them going to a new
5 institution and triggering a whole new episode of payment.

6 DR. NERENZ: That's what I was wondering about.

7 DR. MARK MILLER: And that's what we're trying to
8 think through [off microphone].

9 MS. KELLEY: I think the work that we've done in
10 the past and CMS' work has confirmed this as well, that when
11 we looked at patients who used LTCHs and compared them with
12 similar patients who didn't and we looked across the episode
13 of care, so different settings, we found that Medicare pays
14 a lot more for kind of the lower-acuity patients who use
15 LTCHs than Medicare would if they had not used an LTCH. But
16 for the highest-severity patients, the differences really
17 narrowed. And so I think that's one of the reasons why
18 we've been thinking about trying to identify who are those
19 very high acuity patients.

20 MR. HACKBARTH: Yeah. That piece of research that
21 Dana just described was something we did a number of years
22 ago and was one of the foundational pieces for our

1 recommendation that what we needed to do was establish
2 patient criteria on who it made sense to pay this much
3 higher level of payment for as opposed to open-ended
4 criteria on who goes into an LTCH, could we make sure this
5 expensive resource was really focused on the people who
6 would most benefit from it. But that approach of narrowing
7 patient eligibility has just never come to fruition for a
8 number of --

9 MS. KELLEY: One thing we've been looking at --
10 and I put up the slide here about developing LTCH criteria,
11 and this is something I know that CMS is working on as well,
12 and there's more and more literature about the CCI patient.
13 And, you know, sort of just focusing more on trying to
14 figure out who they are, and these are some definitions that
15 have been put forth from a number of different sources. So
16 these are the kind -- and you saw that Julian and I were
17 looking at the use of intensive care services. So these are
18 some of the kinds of things we're exploring.

19 DR. BAICKER: Just following up along those lines,
20 in several different contexts, we've heard about potential
21 alternative paths for patients' post-acute care, and we've
22 got bits and pieces of information about the characteristics

1 of patients in this setting and the characteristics of
2 patients in that setting. Going forward, not necessarily
3 for this update decision, it would be, I think, helpful to
4 sort of lay out the overlapping patient populations in the
5 different settings and the outcomes as were measured. I
6 heard in the introduction about how they're not yet measured
7 consistently across those settings, but understanding the
8 fungibility of patients across settings based on their
9 characteristics would be really helpful in thinking about
10 how to harmonize these. That's just a future data request.

11 MS. KELLEY: In the short term, I think the
12 results from the CARE demonstration might also inform that
13 consideration. So that's something I can summarize and
14 bring to you for next time.

15 MR. HACKBARTH: Okay. Peter, what I'm going to
16 suggest is that from the rest of the way, why don't you, in
17 addition to asking any clarifying questions you have, also
18 let us know what you think about the recommendation and
19 combine Rounds 1 and 2 the rest of the way around to make up
20 time? Is that okay with you?

21 MR. BUTLER: Okay.

22 DR. MARK MILLER: [off microphone].

1 MR. BUTLER: I'm ready. We're just getting more
2 data in on outcomes and so forth. Overall -- and you
3 loosely mentioned mortality rates, for example, so in a
4 hospital it may be 2 or 3 percent, and you've already
5 demonstrated in, for example, that previous slide that over
6 10 percent of the ones that are coming from -- what's the
7 overall mortality rate in LTCHs? Do you know?

8 MS. KELLEY: I do.

9 MR. BUTLER: Because it's just a whole -- it's a
10 totally different exercise.

11 MS. KELLEY: It varies quite a bit by diagnosis.
12 There is -- I thought I had it right here.

13 Off the top of my head -- I don't want to misspeak
14 -- it varies quite a bit by diagnosis, and -- oh, I know
15 what I did. I looked at cases that were very short-stay
16 outliers compared with cases that were not short-stay
17 outliers, so eliminating the kind of middle short-stay
18 outlier cases, and one of the things that varied
19 tremendously was the mortality rate. So for the patients
20 who stay sort of beyond -- who have sort of the longer
21 regular LTCH stay, the mortality rate in facility was quite
22 low. It was about 7 -- for a sickly population low, 7

1 percent. For patients who had the very shortest stays, most
2 of them -- or 40 percent of them die in the LTCH. So there
3 is a -- the shorter-stay patients do tend to -- are much
4 more likely to die in the facility. Within a year following
5 discharge from the facility, many of these -- almost half of
6 these patients have died.

7 MR. BUTLER: Well, this slide here that you have
8 up, it's stunning that -- also in the chapter it says that
9 if you're transferred with mechanical ventilation, 69
10 percent die within a year.

11 MS. KELLEY: Now, that was not based on our
12 analysis. That was another study.

13 MR. BUTLER: Right, another study that did suggest
14 that these --

15 MS. KELLEY: But it's very striking.

16 MR. BUTLER: -- are obviously sick people. And
17 how palliative care and hospice care fits in and kind of --
18 you know, and how that is embraced or not is -- this is --
19 now I'm going to start sounding like a death panel or
20 something. I don't want to do that, even though I use those
21 words. But now that I've done it -- but I have no doubt
22 that the literature -- the study suggests that if you're in

1 an area where there's significant population, that having a
2 critical mass of -- being able to do particularly
3 ventilation in a dedicated unit that has a significant
4 population can be done efficiently and effectively, better
5 than in ICUs in the hospitals that are spread all -- so I'm
6 supportive of the concept.

7 So one other just comment that strikes me.
8 Yesterday we looked at home health and said there are 12,000
9 home health agencies, you know, a little bit of everything,
10 and they're a key part of -- and here two companies have
11 over half of the business. So it just strikes you -- and
12 they're for-profit. It just strikes you, two very different
13 kind of approaches to key parts of the post-acute world, and
14 you're going to get different approaches. The for-profits
15 are more responsive to short-term incentive and
16 opportunities, plus and minuses. They manage more tightly,
17 et cetera. But I think they're just so different cultures.
18 I think we need to think about that, too, and who the -- you
19 know, how this post-acute spending evolves. We're big
20 believers in a pluralistic system here in the country, yet
21 we're kind of making decisions ultimately that really could
22 put these things in hands that maybe are good or maybe are

1 not. It's just something we need to think about. And I'm
2 supportive of the recommendation.

3 DR. CHERNEW: I'm good on the recommendation.

4 MR. KUHN: A couple quick comments, one picking up
5 a little bit where Peter was asking, one of the things LTCHs
6 talk a lot about is their ability to wean patients off
7 vents. How does their performance compare to SNFs or to
8 ICUs or others? Are they that materially different?

9 MS. KELLEY: I don't know how they compare to
10 ICUs. I think it's fair to say that there are very, very,
11 very few SNFs that will take ventilator patients these days.
12 So I suspect, you know, they're -- I don't know what their
13 weaning success would be, but I think there are very few of
14 them that do it at all.

15 MR. KUHN: Okay. Thank you.

16 MR. HACKBARTH: So, Dana, in places on the map
17 where there aren't LTCHs, the ventilator patients are just
18 staying in the acute hospital?

19 MS. KELLEY: They stay in the acute-care hospital
20 for the most part, although -- and some -- there are LTCHs
21 that do serve, you know, much more of a regional and even
22 national population. There are LTCHs that take patients

1 from around the country and, you know, one would presume
2 that many of those patients come from areas where there
3 aren't LTCHs or don't have LTCHs that have, you know, the
4 name recognition that some LTCHs do.

5 MR. KUHN: Thank you. A second quick question,
6 again, going back to Peter's query about the mortality
7 rates. I, too, have been very curious about this over time.
8 When CMS made the policies on the short-stay outlier, did
9 that change the classification of those patients much? Did
10 we see any movement, I guess, in the mortality rates for
11 short stays when that policy went into place? Because I
12 think the concern when that was put in place was that LTCHs
13 were being used as a very high cost hospice, and there was
14 an attempt to try to kind of manage that. So did that
15 policy have the intended effect?

16 MS. KELLEY: I would have to look at that more
17 closely. The strange quirk of the short-stay outlier policy
18 is that the formula is such that about 30 percent of
19 patients are always going to be short-stay outliers. So
20 it's a moving target.

21 The new very short stay outlier payment policy,
22 which effectively limits payment to an IPPS, you know,

1 similar rate for the shortest-stay patients is not linked in
2 the same way. And so it will be interesting to see whether
3 the changes in payment do affect admission of those
4 patients.

5 I think CMS' feeling is that the shortest-stay
6 patients who die so quickly, similar to what Peter was
7 saying, that moving these patients so late in the course of
8 their life is disruptive to them and to the family, and that
9 a payment policy that encourages that movement is maybe not
10 in the patient's best interest. And certainly to the extent
11 that the cost of caring for the patient is so much lower
12 than average, it's not in Medicare's interest as well.

13 MR. KUHN: Thank you.

14 And then a final quick question here. On the 25-
15 percent rule, and when that was put in place in '05, when --
16 and I'm trying to remember. What was MedPAC's position on
17 that rule at that time? Did they support CMS in that? I
18 think MedPAC was more kind of in the patient criteria
19 classification.

20 MR. HACKBARTH: Exactly. We saw the 25-percent
21 rule as distinctly a second-best option.

22 MR. KUHN: That's what I recalled. I just wanted

1 to be sure if I remembered that right.

2 MS. KELLEY: We did encourage CMS, however, if
3 they were going to have a 25-percent rule, that it be
4 applied across the spectrum of providers and not just to
5 hospitals within hospitals, because increasingly -- and
6 you'll note in your materials this year that I didn't even
7 break out hospitals within hospitals and free-standing
8 facilities because increasingly it's very difficult to tell
9 the difference between the two. Is an LTCH that's across
10 the street from a hospital different from one that's on the
11 second floor of a hospital? And certainly I can't see
12 differences necessarily in their margins, in their costs, in
13 their -- you know, it doesn't seem to be a meaningful
14 distinction, and so we did encourage CMS, if they were going
15 to have a 25-percent rule, that it should be applied
16 uniformly.

17 MR. KUHN: Thank you. That's helpful. And I did
18 notice that distinction, that the hospital within a hospital
19 is not in this set of materials. I was curious why, so
20 thanks for the explanation.

21 I do support the recommendation.

22 MR. HACKBARTH: And you were one of the authors of

1 the 25-percent rule.

2 MR. KUHN: I remember it well.

3 [Laughter.]

4 MS. UCCELLO: Can you remind me where these
5 patients are coming from? Are they all or nearly all post-
6 acute hospital, or are they coming from anywhere else?

7 MS. KELLEY: About 81 percent come directly or
8 within three days from the acute-care hospital, and the rest
9 do come from the community. The community admits look very
10 different and predominantly fall into DRGs such as pressure
11 sores, you know, they tend to be more of the skin DRGs and
12 wound care, and much less respiratory diagnoses.

13 MS. UCCELLO: And so this wound care, because that
14 leads to another question I had on the increase in cases
15 with infections. These are coming from the community or--

16 MS. KELLEY: No. The information I put on
17 infections in the chapter, those are all patients, so it's
18 not just community patients.

19 MS. UCCELLO: Okay. So are those infections at
20 admission or just -- so are these indicating poor quality in
21 other settings, aside from any coding?

22 MS. KELLEY: Sure. The research is showing that

1 there are much -- quite a bit of growth in the admission --
2 of patients admitted with existing infections, so, yes, they
3 are coming from other facilities. There's very great
4 regional differences because in any particular region there
5 will be different infections circulating in hospitals. But
6 for the most part, we are seeing a big increase in patients
7 who are admitted with infections.

8 It's hard to tell whether -- it's hard to
9 differentiate, however, patients who -- from the data, from
10 the claims data patients who acquire infections in the LTCHs
11 from patients who had them when they were admitted. So my
12 information about the increase in admissions with infections
13 comes from smaller analyses that were done and published in
14 the literature.

15 MS. UCCELLO: Thank you. I support the
16 recommendations and again reiterate the concern here is
17 that, you know, we really need to think about all of these
18 different settings together.

19 DR. DEAN: The bar graph that you showed of where
20 patients were discharged to, that's nationwide data, right?

21 MS. KELLEY: Yes.

22 DR. DEAN: Because it would seem that it's

1 probably affected because in some areas LTCHs are easily
2 available, others places they're not available.

3 MS. KELLEY: Oh, sure.

4 DR. DEAN: I would think that would really have an
5 impact on this data.

6 MS. KELLEY: Yes. We can try to break --

7 DR. DEAN: I don't know if there's a way to break
8 it down --

9 MS. KELLEY: -- that out regionally. We might be
10 able to do that. We will look into that.

11 DR. DEAN: Okay. What about -- maybe it's in here
12 and I missed it, but the payer mix between for-profit and
13 not-for-profit facilities, is there a difference there? I
14 suspect there might be?

15 MS. KELLEY: Not as much as you would think. For
16 both types of facilities, Medicare is close to half of their
17 revenues, and often the for-profits have a higher share, a
18 slightly higher share of Medicaid patients.

19 DR. DEAN: Do they really?

20 MS. KELLEY: Yeah, so it's not what you would
21 expect necessarily.

22 DR. DEAN: Okay.

1 MS. KELLEY: Although they may -- I suspect that
2 the nonprofits may have a higher share of uninsured
3 patients.

4 DR. DEAN: Okay. All right. Thank you.
5 Interesting, for all these same reasons. We've got this
6 whole collection of different kinds of providers doing --
7 and a lot of overlap between what they do, and we really
8 need to rationalize that somehow.

9 I support the recommendation.

10 MR. HACKBARTH: Okay. Alice?

11 DR. COOMBS: So I agree with just being able to
12 drill down to a granular level as to what the -- the
13 difference between the nonprofits and the for-profits have
14 in terms of the clinical diagnosis.

15 I just want to add to the infections, Cori, the
16 infections that are happening now are a little different.
17 There are those acquired infections from the decubiti, but
18 if they come from the hospital -- some of them are actually
19 wound infections that are on vacs --

20 MS. KELLEY: Sure.

21 DR. COOMBS: -- and when you have a physician on a
22 wound infection with a vac, it really actually is a very

1 costly endeavor for these patients in this venue.

2 In terms of the ventilation, in terms of the
3 success, I was so glad to hear you, Dana, say you didn't
4 know, because we don't know, and I'm in the critical care
5 area, as to how well these people do, and it really is
6 variable in terms of them going to an LTCH that kind of
7 really, really specializes in vents and being able to do a
8 lot of different innovations to try to wean people off the
9 vents.

10 I think that when you look at the for-profits, one
11 of the things that comes to mind for me is the very type of
12 patients in terms of comorbid conditions. For instance,
13 there are some that would probably incorporate some of the
14 quads, who is very labor intensive, and in terms of not only
15 having respiratory failure, but, you know, the combination
16 of wound care as well as some even need to be on dialysis.
17 And dialysis in and of itself, when I get ready to place a
18 patient, it makes it very difficult if the patient is on
19 dialysis and on the ventilator at the same time.

20 MS. KELLEY: I've heard that from others, as well.
21 That is a very difficult --

22 DR. COOMBS: So you only have a very, very few

1 number of LTCHs within a given region that can do both vents
2 and dialysis at the same time, and that's really a struggle.

3 I support the recommendations.

4 DR. REDBERG: Excellent presentation. My concerns
5 about this -- you know, for the other post-acute care that
6 we've looked at, I felt like they were really helping our
7 beneficiaries and we just had to kind of think about
8 allocation being wiser. I'm not convinced that LTCHs are
9 actually helping our beneficiaries at all because there are
10 parts of the country where they don't have any and I haven't
11 heard any indication that beneficiaries are doing any worse
12 in those parts of the country. The mortality rates, we
13 didn't see any data on improved outcomes. And if you look
14 at the mortality rates of patients from the literature, it's
15 that survival is less than ten percent for patients with two
16 organ system failure. That was cited in the --

17 MS. KELLEY: Right. That's not our work, that's -
18 -

19 DR. REDBERG: -- in the reading material.

20 MS. KELLEY: Right.

21 DR. REDBERG: Right. I understand. And
22 certainly, I mean, in my clinical experience, that is true,

1 and the weaning rate is very high.

2 And so I just wonder whether we should be looking
3 at sort of the big picture, if this is the right way to be
4 spending Medicare resources, because I don't think that this
5 is a population we're helping by long-term -- we're just --
6 as Herb said, it's kind of a very expensive hospice care.
7 You know, I think a lot of the end-of-life spending that
8 Medicare spending is probably going into LTCHs and people
9 aren't getting better.

10 And so a lot of this might be related to the lack
11 of end-of-life discussion planning issues. If patients
12 understood they were going to go be on a ventilator in a
13 long-term care hospital or their families understood, for
14 many, many months, and then still die, I'm not sure people
15 would choose that because that's not really, I don't think,
16 in our beneficiaries' interest.

17 And so I have a lot of concerns about this use of
18 Medicare resources because I don't see the benefits to
19 patients. And clearly, things are -- I mean, some of those
20 are related. I think people that are on long-term vents are
21 more likely to get pressure sores, of course, because
22 they're not moving because they're on a ventilator. They're

1 more likely to get infections because they're in an ICU or
2 in a hospital with multiple lines that get antibiotics. I'm
3 sure MRSA has become a big part of that, and we're just
4 seeing more and more. And as our population ages and has
5 more and more comorbidities, I think this is going to be a
6 growing part of the demographic and something that we really
7 need to pay attention to.

8 You did note in the mailing materials that there
9 were some outlier payments for patients who are
10 extraordinarily costly. Are there any particular areas that
11 lead to outliers, or are they --

12 MS. KELLEY: I'll have to get back to you. Do you
13 mean by diagnosis or -- I'll have to get back to you on
14 that. I have done that work. I, just off the top of my
15 head, I --

16 DR. REDBERG: So I support the Chairman's draft
17 recommendation, although I will note that, once again, I
18 think the Chairman may have been overly generous in this
19 recommendation.

20 MR. ARMSTRONG: You know, interestingly, I was
21 going to go down a similar path to the one that Rita just
22 went down. I assume that if there wasn't a payment category

1 for long-term care hospitals and we just paid at the acute
2 care hospital rates, it would cost the program much more.

3 Is that correct?

4 MS. KELLEY: It would cost the program more?

5 MR. ARMSTRONG: Yeah.

6 MS. KELLEY: If there weren't an LTCH?

7 MR. ARMSTRONG: If we just paid -- I assume --
8 let's assume the vast majority of these services will have
9 to be provided in some other setting --

10 MS. KELLEY: Mm-hmm.

11 MR. ARMSTRONG: -- and that a lot of them would be
12 in the acute care hospital --

13 MS. KELLEY: And become outliers in the acute care
14 hospital?

15 MR. ARMSTRONG: Yeah. Would that be a much more
16 expensive --

17 MS. KELLEY: No, I don't think it would. I think
18 it would be less costly, even if there were outliers in the
19 hospital.

20 DR. COOMBS: I can respond in that I'm a critical
21 care doctor and it would be incredibly expensive for --

22 MS. KELLEY: For the hospital.

1 DR. COOMBS: No, for Medicare --

2 MR. ARMSTRONG: That's what I meant.

3 DR. COOMBS: -- to actually pay, because you're
4 going to be paying for vent care. In some hospitals, they
5 don't have a step-down unit and the patient wouldn't go to
6 the floor, so that you're going to be billing for an ICU
7 rate.

8 MR. ARMSTRONG: Yeah.

9 MR. GEORGE MILLER: It's a DRG.

10 MS. KELLEY: Right.

11 MR. GEORGE MILLER: It's going to cost the system
12 less. The hospital is going to lose a gazillion dollars.

13 DR. COOMBS: Right. Well, that's true. That's
14 true. The hospital will lose money --

15 DR. DEAN: George picked up on that right away.

16 DR. COOMBS: The hospital will lose money --

17 [Laughter.]

18 DR. REDBERG: Very well said, George.

19 DR. MARK MILLER: Run the gazillion down.

20 [Laughter.]

21 DR. MARK MILLER: This comes back to this
22 discussion over here that I think might have triggered --

1 with David -- of thinking about how the allocation between
2 these two sectors might be more fair, and so keep that
3 thought in mind. I'm sorry, Scott.

4 MR. ARMSTRONG: Yeah. I just -- it really was
5 striking me that I wonder if it would be worth just modeling
6 out, what if this payment category just didn't exist, and if
7 that would -- what the implications, both in terms of how
8 care systems are organized, but the cost to the program.
9 That's probably more than we could do if it hasn't been done
10 already before we make these decisions in January. But it
11 just -- you know, we're sort of waiting for the integration
12 of post-acute care bundles and maybe there's other ways of
13 simplifying this by just taking out certain payment
14 categories in the meantime.

15 DR. HOADLEY: I'd just make a quick comment back
16 on this last point. I mean, I think it's really
17 interesting, and some of the qualitative stuff I did a few
18 years ago -- the opportunity to compare areas that do and
19 don't have them actually makes some ability to think about
20 that more than just as a calculation, and we certainly
21 talked to people about what happens to these patients and
22 there are some opportunities there.

1 Yeah, I'm supportive of where we are in this, but
2 obviously -- you know, this, I think, has been a really good
3 discussion and there's a lot of bigger issues around this.

4 DR. NAYLOR: I also support the recommendation but
5 would like to follow up on -- and I think that this path
6 that you're taking is exceedingly important, taking a look
7 at what the experience is like for the people who are
8 spending a long time in ICU, then going to an LTCH and dying
9 within 25 days, I mean, just understanding, because it's not
10 the same category of people that goes from a short-term and
11 spends nine months in a facility and has a positive outcome.
12 So I think uncovering and unbundling who they are.

13 And it would lead me to think that real
14 opportunity here is -- especially when you're seeing the
15 growth in diagnosis around respiratory, end-stage
16 respiratory, et cetera, is to really think about the kind of
17 investment we need to be making in palliative care, in
18 hospice, and not extending hospital care but rather early
19 identifying a population that could benefit from entirely
20 different services.

21 Let me also say that in home health, there's a
22 report out very recently that looked at what people are

1 experiencing and the amount of ventilator care, for example,
2 and medical and nursing tasks that family caregivers are now
3 being asked to do without any investment in them. So over
4 50 percent reported that they have huge tasks, including
5 ventilator care, managing complex medications and other
6 therapies, and nobody has prepared them for these things.

7 So I think that there are many sides to this and
8 many alternative paths. I would agree with the thought that
9 we should really try to unbundle who is it that shouldn't be
10 in this service at all and would benefit from a higher
11 quality of life and a higher quality dying without it.

12 DR. HALL: I'm in favor of the recommendations.

13 MR. GEORGE MILLER: Yes. I think Rita teased out
14 what my original question was about the fact that it's a
15 better quality of care if there are better outcomes with or
16 without the LTCH. So based on that, in general, I support
17 the recommendations, but I think the question has been
18 raised: Is this the best use of the Medicare fund program,
19 particularly with this particular segment of the population.
20 And the question really in my mind is not if this didn't
21 exist, as Mary was just outlining. Are there better
22 alternatives to use of the dollars more wisely, especially

1 with the current outcomes that we know.

2 The fact that health care has evolved and changed
3 over the years with technology, we may need to go in a
4 different direction. That's a bold statement for MedPAC to
5 make, but maybe we should make that statement.

6 DR. SAMITT: I'm thinking in the general direction
7 of where Rita and Scott were. You know, although I
8 recognize Scott's desire to do some modeling around what
9 life would be like without this payment category, but my
10 interest is really to understand whether LTCHs do offer
11 beneficiaries higher quality outcomes in a more efficient
12 manner. If they don't, then I would actually think that
13 this recommendation is generous. If we feel that that is
14 not the right ultimate setting -- the payment barriers aside
15 -- for beneficiaries at end of life, then I think to offer a
16 scenario where there are such great margins is really a
17 disservice to Medicare.

18 However, if they do offer an advantage in some
19 ways, then I would preserve the recommendation as is, and I
20 don't know if there's a way to get at that answer, but I'm
21 struggling with this. I think, at a minimum, I think the
22 recommendation is good,. It may border on generous if the

1 use of this forum does not make sense for beneficiaries.

2 DR. NERENZ: I support including with some of the
3 caveats that Craig and others have made.

4 DR. BAICKER: Yes, I'm supportive, as well.

5 MR. HACKBARTH: Okay. Thank you very much, Dana.
6 Excellent job.

7 So we are now roughly a half-hour behind schedule.
8 I think that probably means that we're going to run over by
9 about 15 minutes for Commissioners. Does that pose a
10 problem for anybody in terms of plane or train schedules?

11 [No response.]

12 MR. HACKBARTH: Okay. So we'll try to move as
13 quickly as possible, but I do think we'll run over a little
14 bit, and George, my apologies for that.

15 Okay, Kim.

16 MS. NEUMAN: Good morning. So we're now going to
17 talk about hospice.

18 The Medicare hospice benefit provides palliative
19 and supportive services for terminally ill beneficiaries who
20 choose to enroll. By enrolling, the beneficiaries agrees to
21 forgo curative treatment for their terminal condition.

22 In 2011, over 1.2 million Medicare beneficiaries

1 used hospice care and received it from over 3,500 providers.
2 And Medicare spending totaled about \$13.8 billion.

3 So I have a couple slides with some background on
4 hospice and the Commission's prior work and recommendations
5 in this area. In the interest of time, I'm going to try to
6 go quickly through this, but I'm happy to address questions.

7 On this first slide, we just note that when the
8 benefit was implemented in 1983, it was done so on the
9 presumption that hospice would be less costly than
10 conventional end-of-life care. And so the Congress placed
11 two constraints on the benefit and eligibility criteria.
12 The benefit is for patients who have a life expectancy of
13 six months or less, and there is a cap on the amount of
14 payments an individual provider can receive each year. It's
15 a limit in the aggregate on the average payments, a little
16 less than \$24,000 per patient on average.

17 This next slide reviews the Commission's work. In
18 2008 and 2009, the Commission looked at hospice in depth and
19 found some notable trends. From 2000 to 2007, we saw an
20 increase in the number of hospice patients, nearly doubling
21 over eight years; Medicare spending more than tripled over
22 the period; the number of providers grew by almost 45

1 percent, mostly for-profit providers entering the market.
2 Average length of stay increased by about 50 percent, driven
3 by increased length of stay for patients with the longest
4 stays. And we saw for-profits having longer stays than
5 nonprofits.

6 We also had information from a panel of hospice
7 physicians and executives that gave reports of lax
8 admissions practices and recertification practices among
9 some hospice providers and also concerns about questionable
10 financial arrangements between some hospices and nursing
11 homes.

12 So this led us to look at the hospice payment
13 system, and we found evidence that the payment system is not
14 well matched with the intensity of care throughout an
15 episode. Medicare makes a flat payment per day (whether a
16 visit is provided or not), and hospice service intensity
17 tends to be greater at the beginning of the episode or at
18 the end of the episode near the time of the patient's death.
19 So as a result, long stays are more profitable than short
20 stays.

21 This led the Commission to make a recommendation
22 to reform the payment system to make it better aligned with

1 intensity of care throughout an episode. This is the U-
2 shaped curve recommendation. And PPACA gave the Secretary
3 the authority to revise the payment system in 2014 or later,
4 as she determines appropriate. So it's not clear what will
5 happen here, and we have a standing recommendation for
6 payment reform in this area.

7 We also made a number of accountability
8 recommendations. I'm going to touch on two quickly. The
9 first is the face-to-face visit requirement. Medical
10 directors told us that it was sensible when a hospice
11 patient reached 180 days to have a physician or nurse
12 practitioner visit that patient before determining whether
13 they continued to be eligible. And so that led to the face-
14 to-face visit recommendation, which PPACA adopted and was
15 implemented in 2011.

16 One other thing of note is that we heard from
17 hospice medical directors that there were some hospices that
18 were admitting patients with little regard for the
19 eligibility criteria, and they suggested that focused
20 medical review target providers with unusual utilization
21 patterns. And so the Commission made a recommendation for
22 focused medical review. PPACA adopted it effective January

1 2011. But that recommendation has not -- or that provision
2 has not been implemented by CMS, so we continue to have a
3 standing recommendation there.

4 So, with that, that brings us to our latest data
5 and our framework, which we've used across the sectors.

6 This first chart shows the change in the supply of
7 hospices, which has increased since 2000. That green line
8 is the total number of hospices. You see over 1,300 new
9 providers since 2000. And the yellow line is the number of
10 for-profits. So the growth in the total providers is driven
11 largely by the growth in for-profits, and that has continued
12 in 2011.

13 The next chart shows the increase in hospice use
14 among Medicare decedents. What we see is that in 2011, 45.2
15 percent of decedents used hospice, up from 44 percent in
16 2010 and up from about 23 percent in 2000. And this
17 suggests greater awareness of and access to hospice services
18 over time.

19 Across a wide range of beneficiary characteristics
20 (age, race, urban/rural, gender, fee-for-service/managed
21 care, dual and non-dual eligibles), hospice use among
22 decedents increased between 2010 and 2011.

1 As we've seen before, minorities and beneficiaries
2 in more remote counties have lower hospice use rates than
3 other beneficiaries, but hospice use has been growing among
4 all of these groups.

5 This next chart shows the growth in the number of
6 hospice users, exceeding 1.2 million in 2011, up about 5
7 percent from the prior year.

8 Average length of stay among decedents, which grew
9 from about 54 days in 2000 to 86 days in 2010, held steady
10 at 86 days in 2011.

11 The average length of stay growth we've seen since
12 2000 has been primarily growth in length of stay among the
13 longest stays. The 90th percentile in length of stay grew
14 from 141 days in 2000 to 241 days in 2011, although growth
15 has slowed in recent years. Length of stay for shorter
16 stays has been relatively stable, as you see. The median
17 length of stay was 17 days for most of the decade; it edged
18 upward to 18 days in 2010 and returned to 17 days in 2011.

19 As we've talked about previously, both very short
20 stays and very long stays are a concern. With very short
21 stays, there's concern that the patient doesn't get the full
22 benefit that hospice has to offer. And with long stays,

1 especially when it's concentrated among certain providers,
2 the concern is that there may be some providers pursuing a
3 business model that seeks to maximize profit by enrolling
4 patients likely to have long stays or in the extreme case
5 enrolling patients that do not meet the eligibility
6 criteria.

7 So with this next slide, I'm just going to take a
8 step back for a moment and consider the latest length-of-
9 stay data in the context of payment reform.

10 Some might say that the leveling off of length of
11 stay growth means that payment reform is not needed. But
12 that line of argument ignores a fundamental problem with the
13 current payment system.

14 Inaccuracies in the current payment system make
15 long stays more profitable than short stays, which make the
16 payment system vulnerable to patient selection.

17 As shown on this slide, length of stay varies by
18 observable patient characteristics like diagnosis and
19 patient location. This means that hospices that choose to
20 do so have an opportunity to focus on more profitable
21 patients.

22 Consistent with that, we see for-profit providers

1 having substantially longer lengths of stay than nonprofits
2 -- 102 days versus 69 days on average.

3 Selection issues distort the distribution of
4 payments across providers, and opportunities for selection
5 can only be lessened through payment reform.

6 So next we have a slide on the hospice cap. As I
7 mentioned quickly at the outset, the hospice payments each
8 year are capped for each provider at an average of \$24,000,
9 roughly, per patient. And in 2010, we estimate about 10.2
10 percent of hospices exceeded the cap. That's down from 12.5
11 percent in 2009. And for those that exceeded the cap, the
12 amount that they went over the cap was less in 2010 than
13 2009. So this suggests that hospices are making adjustments
14 in their admissions practices in response to the cap.

15 Next, on to quality. We don't have any data to
16 evaluate trends in hospice quality. Per PPACA, hospices
17 will begin reporting quality measures in 2013, and there are
18 two measures. The first is an NQF-endorsed pain measure.
19 The second measure is not a traditional quality measure.
20 It's a measure that CMS created to get a sense of what types
21 of quality indicators hospices currently track, which is
22 intended to help CMS identify measures for the future. So

1 under the second measure, hospices will report whether they
2 track at least three patient care quality indicators and
3 what those indicators focus on.

4 Two more points on that. Hospices that don't
5 report in 2014 will receive a two-percentage-point reduction
6 in their update for 2014, and given the penalty and the
7 scope of these measures, we anticipate high rates of
8 participation and reporting in 2013.

9 So now on to access to capital. First, just to
10 point out, hospice is less capital intensive than some other
11 Medicare sectors. Overall access to capital appears
12 adequate. Among free-standing providers, we have reports
13 from for-profit chains that indicate generally strong
14 revenue growth as well as investments via acquisitions of
15 other providers or investment in new startups. This, along
16 with the overall growth in the number of for-profit
17 providers, suggests adequate access to capital for this
18 group.

19 For nonprofit free-standing providers, information
20 on their access to capital is more limited. Provider-based
21 hospices have access to capital through their parent
22 providers, and as we've heard in the other sessions, home

1 health agencies and hospitals appear to have adequate access
2 to capital.

3 So this brings us to Medicare margins. We
4 estimate in 2010 that the Medicare margin is 7.5 percent, up
5 slightly from the margin in 2009. Note how we calculate
6 margins. We assume cap overpayments are fully returned to
7 the government, and we exclude non-reimbursable costs, which
8 means we exclude bereavement costs and the non-reimbursable
9 portion of volunteer costs. If those costs were included in
10 our margins, it would reduce our margin estimates by at most
11 1.4 percentage points and 0.3 percentage points,
12 respectively.

13 This next chart shows the distribution of margins
14 across providers. Free-standing hospices have higher
15 margins than hospital-based and home health-based hospices.
16 And the lower margins of provider-based hospices are due in
17 part to their higher indirect costs, which are likely
18 inflated due to the allocation of overhead from the parent
19 provider. If provider-based hospices had the same level of
20 indirect costs as free-standing hospices, their margins
21 would be substantially higher, and the aggregate Medicare
22 margin across all providers would be an estimated 1.9

1 percentage points higher.

2 We also see from this chart that for-profit
3 hospices have a higher margin than nonprofits, 12.4 percent
4 compared to 3.2 percent. However, when we look at free-
5 standing providers whose costs are not affected by overhead
6 allocation issues, the nonprofit margin is substantially
7 higher, 7.6 percent.

8 This next chart shows how margin vary by length of
9 stay and site of service. In the left chart, you can see
10 that hospice profit margins increase as length of stay
11 increases, as we've noted. The right chart shows hospice
12 profit margins as the percent of the providers' patients in
13 a nursing home increases, and as you can see, hospice
14 margins increase as hospices have more patients in nursing
15 homes.

16 The Commission recommended the OIG study hospice
17 care in nursing homes, and the OIG study found that hospices
18 that focus on nursing homes tend to be more likely to be
19 for-profit, enroll patients with diagnoses that tend to have
20 longer stays, and require less complex care. And the OIG
21 recommended that CMS cut the payment rates for hospice in
22 nursing homes.

1 So this brings us to our 2013 margin projection.
2 We start with the 2010 margin, and we take into account the
3 market basket updates between 2011 and 2013, the phase-out
4 of the wage index budget neutrality adjustment and other
5 wage index changes, and additional costs related to the
6 face-to-face visit requirement and other requirements.
7 Based on these factors, we project a 2013 margin of 6.3
8 percent. One 2014 policy of note is that the wage index
9 budget neutrality adjustment factor phase-out will continue
10 and will reduce the 2014 payments by an additional 0.6
11 percentage points.

12 So, in summary, the indicators of access to care
13 are favorable; the supply of providers continues to grow,
14 driven by for-profit hospices; the number of hospice users
15 increased; length-of-stay growth has leveled off; quality
16 data are unavailable; access to capital appears adequate;
17 the 2010 margin is 7.5 percent; and the 2013 projection is
18 6.3 percent.

19 So, with that, that brings us to the Chairman's
20 draft recommendation, which reads: The Congress should
21 eliminate the update to the hospice payment rates for fiscal
22 year 2014. And the implications of this recommendation are

1 a decrease in spending relative to the statutory update. In
2 terms of beneficiaries and providers, no adverse impact on
3 beneficiaries is expected, nor do we expect any effect on
4 providers' willingness or ability to care for Medicare
5 beneficiaries.

6 And that concludes my presentation.

7 MR. HACKBARTH: Thank you, Kim, and I really
8 appreciate your help in keeping us moving along. You spoke
9 very quickly.

10 MS. NEUMAN: Sorry.

11 DR. MARK MILLER: Try and catch your breath [off
12 microphone].

13 MR. HACKBARTH: Bill, do you want to lead off?
14 And what I'd propose is let's do one combined round here.
15 Any questions or comments, plus your thoughts on the
16 recommendation.

17 DR. HALL: Well, as opposed to a couple of the
18 other things we've talked about today, I think this is one
19 venue of care that we need to actively support. The hospice
20 movement since the year 2000 has really revolutionized --
21 not so much the quality of life but the quality of the last
22 part of life.

1 I agree very strongly with the observations that
2 there needs to be some corrections in payment, and,
3 therefore, I'm very much in favor of the recommendations
4 that you've put forward.

5 DR. NAYLOR: I also agree with the recommendation.
6 I think the variance of margins by different type is
7 something that, you know, you struggle with, hospital-based
8 and so on, but that said -- and I was wondering if we -- so
9 I support the recommendations, but in the modeling that's
10 going to go on with maybe the LTCH work, if we could think
11 about how hospice -- if hospice were to substitute for the
12 eight days in the ICU plus -- I'm just connecting these
13 dots. What would the costs look like for the Medicare
14 program if you were to substitute one type of service like
15 this for what's going on in ICU plus first 25 days of LTCH?

16 DR. HOADLEY: Yeah, I'm fine with the
17 recommendation. I wanted to just talk for a minute about
18 the short-stay and the long-stay kinds of issues. Just as a
19 numbers person, looking at anything where the median and the
20 mean are so disparate, you know, just is dramatic. And I
21 guess one question is, in things like you have on Slide 10
22 where you show the mean lengths of stay for some of these

1 different categories, I wonder if this is a case where,
2 rather than looking at the mean, there's some value in
3 looking at the percentage of cases above some threshold of
4 long stay. It might just get to the exact same results, but
5 it might not. Just, you know, the numbers, when the means
6 and the medians are so far apart, these could be really
7 dramatically swayed by some extremely long cases, and it
8 might just be worth taking a look and seeing if that -- or
9 maybe you've already done that at some point.

10 MS. NEUMAN: Yeah, we do have that data, and I
11 will have that for you next time. You know, we've looked at
12 a percent of stays over 180 days, and it does -- it follows
13 out in these general directions.

14 DR. HOADLEY: Okay. And I guess my other comment
15 is on the short stays, and you talked about why that's a
16 source of concern. Anecdotally, it seems like the cases
17 that I've known from family members or friends that have
18 been short stays are cases where somebody, you know, not
19 because of any situation where there was necessarily a delay
20 in making a decision to go forward, but some kind of a
21 health situation that was sort of accelerating rapidly, and
22 the decision was made, you know, no further treatment, go to

1 hospice, and then the person dies within 24 or 48 hours. It
2 strikes me in situations where -- but, obviously, those are
3 anecdotes. I don't know how common that is. But certainly
4 there's a number of short-stay cases that would be
5 completely legitimate, just the nature of how disease takes
6 on. So I don't know that there's any way to ever try to
7 measure that difference, but I just wanted to put that in
8 there as a thought about how to think about this.

9 MR. ARMSTRONG: I, too, think this is an
10 invaluable program. Given the margins, I think the
11 recommendation is heading in the right direction.

12 Just one question. The percentage of decedents
13 cared for in this program has gone up a little bit in the
14 last year, it just makes me wonder. We think of that as a
15 measure of success, but I just wonder if there's a target
16 that we have for that, you know, if we think that there's
17 like an optimal level, or are we getting close to that? Is
18 that something --

19 MS. NEUMAN: Well, a target is hard. I think
20 everyone agrees that it's never going to be 100 percent
21 because of unexpected and unforeseen situations.

22 MR. ARMSTRONG: Right.

1 MS. NEUMAN: I can tell you that right now there's
2 a range geographically, and we see that number as high as 60
3 percent in some areas. And when I hear people talk about
4 the upper limit, you hear them throw around 60 or 70
5 percent. I don't know how much science is behind that, but
6 it seems like there's more room to go in the aggregate, I
7 would say.

8 MR. ARMSTRONG: I would like an opportunity in the
9 months ahead to talk a little bit about what are ways in
10 which our payment policy might encourage that number to get
11 higher than -- get closer to 60 percent, you know, more
12 consistently. But I want to affirm I support the direction
13 the recommendation is going.

14 DR. REDBERG: As a clinician, I would suggest --
15 first I'll say excellent report, and I'm very supportive of
16 the hospice program, and my patients and their families, the
17 only thing they say to me is they wish they had known about
18 it sooner or they wish they had started in it sooner,
19 because they're so grateful. You know, end of life is a
20 very difficult time, and they really get a lot of care and
21 counseling that's very specialized and appropriate for end
22 of life. I think it's not just the payment policy, but I

1 think clinicians are notoriously poor at recognizing when
2 end of life is there, and perhaps patients and families.

3 But in my own field, cardiology, you know,
4 congestive heart failure is often an end-of-life condition,
5 and we know that cardiologists are very poor at recognizing
6 when the end of life has come. And so that's another reason
7 for under-referral to hospice care, and it is well-
8 intentioned but very unfortunate.

9 I support the Chairman's recommendation.

10 DR. DEAN: I support the recommendation.

11 It occurred to me in our last discussion and the
12 question about the appropriateness of LTCHs versus hospice.
13 I understand that later on we're going to have a discussion
14 about shared decisionmaking. It seems to me this is one of
15 the ideal places to try to introduce that.

16 Because certainly, in my experience -- and it's
17 tied in with the fact patients have to -- the current
18 requirement they give up conventional care. And maybe it's
19 just that those of us, as clinicians, don't understand this
20 well enough to explain it or we don't take the time or
21 whatever. But that frightens so many people into rejecting
22 something that clearly has tremendous benefit, as Bill said.

1 You know, there was at least one study a year or
2 two ago that said that patients that elect hospice live
3 longer than people that go into conventional care.

4 So I think that this is really an area that has a
5 tremendous opportunity for better definition of what the
6 mechanisms or the process is to present this alternative
7 because it has great value in many ways and it clearly isn't
8 being used ideally. We don't always get the right -- and I
9 think we also need to look at this criteria, this six month
10 projected life span. Because, as Rita said, we're terrible
11 at that. And it seems to me there's probably better
12 criteria.

13 I mean, you're asking -- for those patients that
14 do enter with diagnoses that we have some questions as to
15 whether they're really appropriate, what was it that
16 triggered the decision to move to hospice at this time? Is
17 this patient really stable? If they're totally stable and
18 have COPD, is that really an appropriate referral? Or is
19 there some sign that, in fact, things are beginning to
20 deteriorate? And is there a way that we could measure or
21 document -- I mean, I don't know. I'm just brainstorming.

22 But it just seems that we need some better

1 criteria.

2 MR. HACKBARTH: My recollection of the history,
3 Kim, and correct me if I'm wrong, is that both the six month
4 requirement and the requirement that the patient forsake
5 care aimed at recovery were driven, at least in part, by a
6 concern that without those constraints hospice could become
7 a de fact long-term care benefit in the Medicare program.

8 Now we've had other developments recently and
9 litigation that also raise some of those same questions.
10 I'm referring to the case about the improvement requirement.

11 I wonder to what extent this whole area requires
12 some rethink. I know that under PPACA there was a
13 demonstration established to look at the issue of removing
14 the requirement that the patient forego recuperative care.

15 Remind me, Kim, that's in the process of being set
16 up now?

17 DR. DEAN: Isn't there a demo or something that's
18 going on?

19 MS. NEUMAN: It is in PPACA. There were no funds
20 appropriated, and so it's unclear what will happen.

21 MR. HACKBARTH: Okay.

22 DR. DEAN: But some of the private payers, I

1 think, are doing it; right?

2 MR. HACKBARTH: Yes, but there's been some
3 questions about whether the private population is
4 meaningfully different from the Medicare population on these
5 issues, whether the same results would apply.

6 Okay, lots of things, moving parts, in this area
7 that we need to think about how they integrate.

8 Cori.

9 MS. UCCELLO: I am supportive of the
10 recommendation. And I'm also interested in learning more
11 about whether or not the distribution of the payments is
12 appropriate. There's some evidence that payments to nursing
13 homes or for hospice care and nursing homes can be
14 different, maybe lower.

15 There are also program integrity concerns with
16 nursing home hospice, I think.

17 As well as I'm just wondering if services provided
18 to non-cancer patients are different from those of cancer
19 patients. You read about different kinds of outcomes with
20 those two groups, and so trying to think through that would
21 be helpful.

22 MR. KUHN: Kim, two quick questions.

1 First, the issue of the cap. Talk a little bit
2 more about the nature of those hospice that are hitting the
3 cap. Are they geographically in certain states? Are they
4 more kind of long-term care based? Just a little bit more
5 about those.

6 MS. NEUMAN: Sure. The hospices that are hitting
7 the cap are -- the vast majority are for-profit. They tend
8 to be smaller, on average, in terms of their patient load.
9 They are geographically concentrated in certain States, so
10 places like Oklahoma, Mississippi. There's four or five
11 States that have much higher rates than other places. They
12 don't tend to be overly focused on nursing homes.

13 MR. KUHN: And on their characteristics, do they
14 tend to take a certain type of patient with a diagnosis? I
15 mean, do they have, like, more cancer patients than others?

16 MS. NEUMAN: They would have more non-cancer
17 patients than others, but we see a longer length of stay
18 across every diagnosis for these hospices.

19 MR. KUHN: Okay. Thank you. And I support the
20 recommendation.

21 DR. CHERNEW: I also support the recommendation
22 and would say that -- you know, Peter talked about IRFs and

1 LTCHs as exhibits one and two, and I think the rest of these
2 are sort of exhibits three, four, and five to the notion
3 that we have this tendency to segment the system away from
4 where -- what the patient is. Then within each of the
5 segments, we try and set up payment rules. And then we
6 realize that there are problems within those segment rules
7 because we can't deal with the seams between any given
8 system and a bunch of other systems. Then we put in a bunch
9 of regulations. Then the regulations can never be exactly
10 right for a whole bunch of reasons. So we're torn to try
11 and get more information to perhaps regulate better, which
12 we can never seem to do. And there's a huge amount of
13 heterogeneity across all of these, as well.

14 I've had several relatives in hospice and I have
15 to say, the hospice providers in the cases I had were angels
16 in a whole number of ways. I can't even speak highly enough
17 about them. But that doesn't mean that every provider is
18 that way.

19 And so I guess, although I support the
20 recommendation, in the end, our solution can't be to segment
21 payment more, figure out more specific services, figure out
22 how to figure out exactly who gets those services, at which

1 rates, and when, and then regulate. I think the solution at
2 some point has to be to find some patient-centered way of
3 thinking about the system and then making sure that people
4 get the services they need without having to come across
5 these barriers of whether you're a Level 4 hospice or Level
6 1 hospice, and if you're Level 1, you have to move, and if
7 you're Level 4, you can stay, and -- it can get to the point
8 of craziness, if not worse.

9 And so although I support the recommendation, I'm
10 really thrilled at the conversation we had today, which I
11 think seemed to have a theme of "there has to be a better
12 way."

13 MR. HACKBARTH: Yeah. So, I was going to say this
14 at the end, but I'll say it now since Mike lunged.

15 [Laughter.]

16 MR. HACKBARTH: I didn't mean that the way it came
17 out.

18 DR. CHERNEW: No, no, that's fine. I was trying
19 to talk as fast as Kate did.

20 [Laughter.]

21 MR. HACKBARTH: So, I agree with everything that
22 Mike just said. Now, fast forward to the spring.

1 DR. CHERNEW: I'm sorry, Kim.

2 MR. HACKBARTH: We will be looking at the issue of
3 bundling around hospital admissions. Every time that we've
4 taken that issue up in the past, as people start to dig into
5 it, they say, oh, heavens, this is difficult. This is
6 complicated. And we tend to back away from it.

7 You know, we face a really -- and I mean, "we,"
8 the Medicare program, the broader, the big "we" -- a choice
9 here. This path that we're on -- I'm with Mike. I think
10 the silos and all of the things that he said are true and I
11 don't think this is the way out. I think we need to go to
12 broader bundles of payment, but we shouldn't have any
13 illusions about that being easy, either analytically or
14 politically.

15 So I just want to prep people for when we come
16 back to bundling. I want everybody to read the transcript
17 from this morning before they come to the meeting and be all
18 psyched up, ready to go.

19 Peter.

20 MR. BUTLER: How do I follow that? So, I support
21 the recommendation. I also like the fact that the chapter
22 has right at the beginning said, okay, dummies, we made a

1 bunch of recommendations before that were pretty thoughtful.
2 Let's restate them and have them prominent.

3 I think we have an opportunity in this area to
4 educate a lot more maybe than in other areas. And while you
5 had length of stay by diagnosis, in the past, you know,
6 we've had some charts that show the trends and who is a
7 hospice patient and it's rather dramatic to learn that
8 neurological diseases are on such a growth and that cancer
9 is less than half of hospice. But I imagine the general
10 public still doesn't have any appreciation for the full role
11 of hospice and palliative care. So trends and who makes up
12 the hospice population is, I think, important.

13 Not the least of which is that -- and this is
14 where, I think, hospice is a little different kind of silo.
15 As much as I'm into bundling, this is the one tool that
16 helps ease end of life in a graceful way. And so one of the
17 reasons for the disease mention is that Alzheimer's is
18 overwhelming us, and a lot of the neurologic growth, I
19 think, in hospice care is in that area. And if we can learn
20 more about what role hospice actually plays in a disease
21 like that that doesn't have this predictable six-month time
22 frame to it, we might even end up with some kind of revised

1 approach towards a huge disease that is a little different
2 than maybe the benefit is structured today.

3 DR. BAICKER: And here I was to take up Mike's
4 challenge to talk even more quickly.

5 [Laughter.]

6 DR. BAICKER: So, I'm supportive of the
7 recommendation. Hospice, unlike most of the other things we
8 look at, we're actively worried about lengths of stay that
9 are too short and people not taking full advantage of
10 something that would be of great benefit to them.

11 So, I'm also supportive of the recommendation to
12 explore ways to make the benefit more flexible, and I'm
13 taking the caveat that the private sector results may not
14 generalize to what we see here. I think this is an
15 opportunity to explore some of those alternatives, like
16 eliminating the requirement to forego curative care, as
17 well, that might really benefit beneficiaries and not
18 increase program costs.

19 And, of course, there's a great deal of
20 uncertainty about what the optimal length of time is. There
21 is inherently a lot of uncertainty about how long patients
22 are going to be in hospice, and so we have to take all of

1 those lengths of stay with some nuance. But, I think,
2 promoting greater utilization of the benefit would be in
3 everyone's best interest.

4 DR. NERENZ: I'm generally supportive of the
5 recommendation, supportive of the concept of hospice and
6 make sure we want to do things that support its growth, and
7 also supportive of the comments about trying to move away
8 from the silos, okay, all that said.

9 If we could go to Slide 15, please. I'm just
10 struck here again by the striking difference in margins
11 between the hospital-based and the freestanding, and it just
12 echoes something that we have seen now several times. We
13 saw it in the IRFs and I'm even seeing -- back yesterday
14 morning, we were talking about the inpatient and outpatient
15 margins for hospitals, which are seeing negative, negative,
16 negative. And I suppose, in principle, you'd say, well,
17 hospital managers are just bad managers, but I don't think
18 that is true.

19 There's something else going on here -- no, I just
20 -- I want to set that aside. I don't think that's true.
21 But there's something else going on here, and I suspect it
22 has something to do with certain underlying costs that are

1 either built in as a part of program regulation or they have
2 something to do with broader missions that hospitals serve
3 in the community.

4 On page 34 and 35 in the report, you did some
5 analysis of what some of those costs might be here, and I
6 don't want to explore that in detail. Just making the
7 general point, it would be very useful to me to understand
8 if there are, indeed, some essential underlying costs that
9 relate to hospital that find their way into a whole bunch of
10 these different silos, I would very much like to know, do
11 those costs truly add value to patients and families and
12 communities, because I think then we would think about
13 payment adequacy in one way. Or, do they not, and then we
14 would think about payment adequacy in another way. It comes
15 up here, but it just comes up other places, as well.

16 MR. HACKBARTH: Other people, feel free to jump in
17 and correct me if what I say is incorrect.

18 I think that, actually, the answer may vary across
19 the different types of care. In the case of hospice and
20 home health, you're talking about services that ordinarily
21 don't have a big capital infrastructure, bit management
22 structures, and so the allocation of hospital institutional

1 overhead to those types of providers may really make them
2 look like their costs are dramatically higher.

3 When you're talking about an IRF or an LTCH, which
4 has a much more similar sort of structure to a hospital,
5 including some of the regulatory requirements, then there
6 might be other reasons, patients difference reasons, et
7 cetera, for why hospitals perform -- hospital-based perform
8 less well. But I think you do need to take into account
9 that some of the services, it could be driven strictly by
10 the allocation of hospital overhead.

11 DR. NERENZ: Agree, absolutely, although I just
12 would observe in that case, then if hospitals didn't
13 allocate that way, then the margins that we'd see in the
14 other services would be even more negative than they
15 currently are.

16 MR. HACKBARTH: Although you'll recall when we
17 look at the hospital margin, we look at the overall margin
18 and not product line. So it is all --

19 DR. NERENZ: [Off microphone.] Understood.

20 DR. SAMITT: So, I would support the
21 recommendation. In fact, I would predict that we will
22 likely want to be more generous in future years. That

1 perspective comes from, I guess, an organization that is
2 living in the world of the Accountable Care Organization.
3 You can bet that I will not back away from the notion of the
4 importance of bundles. I believe in them, and I'm worried
5 that, actually, as we talk about each of these distinct
6 silos, that Medicare is shouldering a burden that from my
7 point of view should be shouldered by the providers.

8 And so to give you a kind of a sense of the way
9 that we think about hospice in our world is we measure four
10 things. We measure to what degree are patients aware of
11 their options, and are we doing a good job educating
12 patients about end-of-life care and the options that they
13 have?

14 Second, what are the rates of terminally ill
15 patients that are dying in intensive care units or in LTCHs
16 when it doesn't feel humane that that is the way the
17 beneficiaries die?

18 Third is what is our hospice length of stay? Do
19 we have too short of a hospice length of stay to suggest
20 that we're not referring soon enough to hospice? And,
21 likewise, do we have too long of a hospice length of stay to
22 suggest that perhaps hospice wasn't the right choice when we

1 make a recommendation?

2 So I believe that the providers really very much
3 own this responsibility, and while we're thinking of payment
4 methodologies to focus on hospices that are too short and
5 too long, I think in the world of accountable care and in
6 the world of bundles, providers very much step in and take
7 some accountability for that, which is what I think is
8 lacking.

9 MR. GEORGE MILLER: I was very encouraged to hear
10 the physicians' very strong support of the hospice concept.
11 In my own personal experience, the physicians who are
12 hospice physicians just have an incredible understanding of
13 end-of-life care and what should be used and what shouldn't
14 be. I think this is, to echo what the other clinicians
15 around the table have said, this is an area of service that
16 is a huge benefit to the Medicare beneficiaries and also a
17 way to save my gazillions of dollars to the program in an
18 effective and meaningful way. Notwithstanding what Craig
19 said about bundled payments, and I think it can be included
20 in the bundled payments. The difficulty would be is making
21 a decision about what shouldn't be there and what we
22 shouldn't pay and in lieu of the hospice benefit.

1 Again, personal experience and folks who are
2 dealing with end-of-life care, where we direct patients to
3 the hospice. It saves the program a lot of money. It is
4 better for the patients. And understanding the inevitable
5 outcome that some folks are going to die, it is a humane
6 thing to do.

7 So I support the Chairman's draft recommendations
8 and look forward to discussion as we really tackle this
9 issue in the future.

10 MR. HACKBARTH: We finished seven minutes ahead of
11 schedule. Anything more you want to say, Kim?

12 [Laughter.]

13 DR. CHERNEW: Say the same thing slower.

14 MR. HACKBARTH: Right. Okay. Thank you very
15 much.

16 And we'll now have our public comment period.

17 Kim, you'll put up the ground rules.

18 I know you're familiar with the ground rules --

19 MR. KALMAN: I am, and I'll be brief, also.

20 MR. HACKBARTH: So when the light comes back on,
21 that's the end of your time.

22 MR. KALMAN: Okay. My name is Ed Kalman and I'm

1 with the National Association of Long-Term Care Hospitals.

2 I'd like to make three observations.

3 First, with respect to the payment efficiency of
4 cases that go to long-term care hospitals versus cases that
5 stay in acute hospitals, whether it's an ICU or a step-down
6 unit, we did a study a year or more ago where we regrouped
7 all the cases and asked what would Medicare have paid if
8 they stayed in the acute hospitals, and one of the findings
9 that came out of that study, there was a whole bunch of
10 cases where Medicaid [sic] paid less, and the reason was, as
11 you've noted, a lot of these cases would be cost outliers in
12 acute hospitals. Cost in acute hospitals that Medicare pays
13 is overhead for ICUs, operating room, GME, IME, none of
14 which exist in a long-term care hospital. So a long-term
15 care hospital is much more payment efficient for a segment
16 of cases that are chronically critically ill.

17 Secondly, we are very concerned about the 400
18 percent difference in cost outlier patients between low-
19 margin and high-margin outliers, and that defines for-profit
20 versus not-for-profit, which is critical. And we believe
21 that there is a difference. There is a patient
22 characteristic difference, whether it be fragility of

1 illness or whether it be payment source and difficulty in
2 placement, particularly cross-overs and the medically
3 indigent.

4 I think it would be a good idea when you study
5 this issue to take a look at readmissions for higher-margin
6 and low-margin providers, and what you will find is since
7 the long-term care hospitals are keeping them longer, and
8 since RTI found that long-term care hospitals have better
9 readmissions, at least for 30 days out on a case-mix
10 adjusted basis, is that Medicare is also saving money for --
11 with these low-margin LTCHs that serve these cases because
12 they're keeping them and they're not being readmitted to
13 acute hospitals. And they're also probably not going to the
14 SNFs that won't take them because of some payment issues and
15 avoiding those high rates of readmissions. So we think you
16 ought to look at that.

17 Thirdly -- I think we're doing quite well on
18 speed, by the way -- we would like to invite your attention
19 to the fact that CMS is supposed to have an eight percent
20 outlier pool for long-term care hospitals. That is eight
21 percent of all the payments are supposed to go to the
22 outlier cases, which establishes a threshold. CMS has been

1 remarkably inaccurate. Last year, it was supposed to be
2 eight percent, but CMS actually spent six percent. That is
3 a 25 percent error rate, which exists every year. So these
4 hospitals that have very low margins and are probably saving
5 the Medicare program money because they're holding the
6 cases, they're not going, they're preventing the
7 readmissions, they're being paid less for the outlier
8 patients than they should. And that is something that the
9 Commission should look at in terms of whether it's a valid
10 issue and maybe suggest that there be a positive adjustment
11 to account for years of underpayment for cost outlier cases.

12 Finally, just a simple observation on your
13 allocation question that you've asked. The Medicare cost
14 report forces it. If there's a hospital-based provider,
15 like a SNF or a hospice, then the Medicare cost report
16 automatically puts all that high overhead to that square
17 footage. So that's why you're seeing the numbers you see.

18 Thank you.

19 MS. SHEEHAN: Kathleen Sheehan with the VNAA, and
20 I'll be very quick. We'll follow up with a letter.

21 I just wanted to comment today on the discussion
22 that took place regarding looking at are we creating -- or

1 are we looking at a system where we have a group of very
2 efficient for-profit provider delivery systems that are
3 making the high margins, and then you attempt to cut them
4 and then the nonprofit delivery system suffers, and it's
5 similar to the comments that were just made.

6 The nonprofits are certainly taking the most
7 difficult patients. They're also taking patients that are
8 rejected by other providers, where there's extensive travel,
9 particularly in rural communities. But they're taking the
10 more difficult, the more challenging patients. Our members
11 tell us that they actually receive patients that come in the
12 hospital. They have basically one or two days of care and
13 they're gone. And they even have patients that really die
14 within the hour of when they receive them.

15 So they're very concerned about States where there
16 is no Certificate of Need process and there's really rampant
17 competition and much of the things that I think the OIG is
18 looking into related to marketing. I think that many
19 physicians, perhaps, are not aware of some of the
20 requirements that need to be met in terms of placing a
21 patient and are very susceptible to marketing techniques.

22 And so we've urged CMS, and I know that you all

1 have, to look very closely at a moratorium, to be constantly
2 aware of the distinctions with the nonprofits, and to pay
3 particular attention to rural communities, which I think are
4 really struggling in terms of trying to serve patients with
5 hospice care, and home health, as well.

6 MS. ZOLLAR: My name is Carolyn Zollar. I'm with
7 the American Medical Rehab Providers Association,
8 representing the rehabilitation hospitals and units, and I
9 just had a couple of comments.

10 There was a tremendous amount of data discussed
11 during the session on the IRFs and we have some concerns
12 about some of it. We may get back to you.

13 Just to highlight that with respect to the
14 comments on the care tool, everybody had looked forward,
15 very eager to see the apples-to-apples comparison, but that
16 data was 2008 and we're now in 2012 and that there have been
17 some shifts in our IRF data that is not captured by that
18 same tool. So we do see some changes in the acuity of the
19 patients increasing over those four years and increasing
20 change, you know, seeing in their comorbidities as they
21 come. So there may be some changes, that if you're looking
22 only at the care tool, that are not captured now.

1 On the definitions of readmissions, we're spending
2 some time looking at that, too, and I could not tell from
3 the data that was presented, because a lot of the policy
4 discussion is, should there be planned readmissions included
5 in these definitions or not, because frequently in our small
6 world, a patient will have a planned readmission. And if
7 it's lumped into the larger statistic, then it might be
8 deceiving, whereas if it's pulled out, as the Yale studies,
9 which is the basis of the CMS work on readmissions, then the
10 numbers look a little bit different. So I'd mention that.

11 And also, in the area of bundling, we have a
12 proposal for post-institutional rehabilitation and medically
13 complex care, which we've mentioned before, the continuing
14 care hospital, and I'd like to happily mention it again,
15 when you move to your discussions of bundling for post-acute
16 care.

17 Thank you.

18 MR. HACKBARTH: Okay. Thank you.

19 We're adjourned until January.

20 [Whereupon, at 11:46 a.m., the meeting was
21 adjourned.]

22