MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: I'd like to welcome our guests in the audience. Today, we have a series of presentations and discussions related to the update recommendations that go into our March report.

At those of you who follow MedPAC closely know, our final votes on these recommendations will occur at the January meeting, so today we will be discussing a series of draft recommendations. These draft recommendations are my suggested starting point for the discussion, and they are just that. They are a starting point and they're based, in fact, this year on what our recommendations were for each of the providers' sectors in last year's report. But for those of you who are reporters, I'd caution you that these are not staff recommendations. These are my recommendations and, in point of fact, they are drawn from our recommendations last year and they are subject to change based on the discussion that occurs at this meeting.

So update presentations and discussions will take up all of today's agenda and then tomorrow we will turn to some other issues.

We are going to begin today with sort of an

overview presentation on the update process. Evan, are you going to start or is Jeff going to start?

MR. CHRISTMAN: I'm going to start.

Good morning. As Glenn mentioned, first we are going to review some of the solvency and financing issues facing the Medicare program. Some of these will be familiar to you from our previous discussions, but we feel it is important to review these as we begin the recommendation process.

A key financing challenge is that growth for Medicare has exceeded growth in the gross domestic product. In a recent analysis, CBO compared the growth in Medicare per capita to the growth in GDP, adjusting for changes in demographics. The analysis found that over a 30-year period, Medicare spending per capita growth has exceeded GDP growth by more than two percentage points.

For these reasons, Medicare spending has grown as a share of our nation's GDP and it is expected to continue to do so. You can see this on that chart. This chart compares Medicare's revenues and its expenditures as a share of GDP. GDP is an important benchmark for these kinds of analysis because as our national income, it represents our

budget constraint as a society. As a Medicare rises as a share of GDP, it means that we are consuming less of other goods and services.

Historically, Medicare's expenditures have risen roughly by about the same amount as its revenues. In 1970, Medicare expenditures equaled about three-quarters of a point of GDP. By 2000, it was about 2 percent of GDP. And in 2010, it is expected to equal a little over 3 percent of GDP.

In 2008 and beyond, the high rate of Medicare's growth causes Part A expenditures to exceed its revenues, and this causes a deficit in Part A that is shown in the red area in this slide. For a short period, until about 2019, Part A will be able to finance this deficit with its cash reserves. After 2019, the reserves will be exhausted and the revenues committed to Part A will no longer be adequate to cover the expenses of the trust fund. The imbalance will grow over time and meeting the shortfall will likely require a significant source of new revenue.

In the near future, Part B and D will also require greater resources. The green area on this chart represents the general revenue funding that Part B and Part D to

require. The amount of general revenue they require will also grow, from about 1 percent today to 3 percent of GDP in 2030 and by much more in the future. The chart illustrates that Medicare will grow to an unprecedented share of our economy if current trends continue. It will exceed growth in the income of the nation as a whole, growth of the Federal Government's tax revenue, and growth in the income of beneficiaries. I will say more about the burden this will create for taxpayers and beneficiaries in a moment.

The rapid growth in spending would be less problematic if there were not serious questions of the value of what we spend. Geographic variations in the delivery of Medicare suggest that a significant share of Medicare spending does not benefit enrollees. Studies of regional differences in spending and utilization have found that areas with more spending do not resolve in improved patient health or satisfaction. The financial impact of the variation is substantial for all payers, and some have suggested that 25 percent or more of the care delivered by Medicare could be eliminated with no detrimental impact on health outcomes.

In addition, numerous studies have found that

quality in Medicare could be improved. For example, a recent review of quality for Medicare beneficiaries found that almost a third or more of enrollees were not receiving the appropriate care for their conditions. All of these findings indicate that opportunities exist to reduce expenditure growth and increase the value of care provided.

Medicare's financial status indicates the need for action. As I mentioned earlier, the Hospital Insurance Trust Fund is projected to be exhausted in 2019. At this point, it will only have sufficient funds to pay 80 percent of benefits due, and the gap between resources will gradually widen. By 2050, the fund will have resources to pay only 40 percent of benefits due. The financial burden of B and D will also grow.

The Supplemental Medical Insurance Trust Fund, which funds these two benefits, is primarily funded through premiums and a contribution from the general fund. The contribution from the general fund, which constitutes the majority of funding for these benefits, will equal 11 percent of the total Federal Government's general fund revenues in 2008, and the share of the general fund it will require will double to 22 percent of the Federal

Government's general revenues in 2030.

In the long run, all of Medicare, not just Part B and D, will require a greater share of the Federal revenues. After Part A is exhausted in 2019, additional resources will have to be found to fund the shortfall. Funding the shortfall, combined with the funding already committed to Part B and D will raise the share of Medicare funded by the general fund from about 40 percent today to over 50 percent by 2020. As Medicare relies more on the general fund, the resources available for other national priorities will be reduced.

Since most cost-sharing requirements are indexed to growth in Medicare spending, rising spending will also impact beneficiaries directly. One metric for comparing the impact of spending growth on beneficiaries is comparing the change in the Social Security benefit with the change in the Part B premium. As this chart shows, over the last five years, the increase in the Social Security cost-of-living adjustment has been about 5 percentage points a year while the increase in the Part B premium was -- excuse me, the increase in the cost-of-living adjustment was about 3 percentage points a year while the increase in the Part B

premium was over 12 percentage points a year.

This graph shows the Part B premium only. Other elements of Medicare's cost-sharing will also place a burden on beneficiaries. For example, in 2008, all of the Medicare out-of-pocket costs, cost-sharing and premiums for Parts A, B, and D, equaled about 26 percent of the average Social Security check. Because of the rate of spending growth, the average total Medicare out-of-pocket spending is expected to total over 40 percent of the average Social Security benefit in 2030, and this estimate assumes that SGR is not overridden. If it is, the share in 2030 would be even higher.

These findings indicate that both beneficiaries and taxpayers have a stake in controlling the growth of Medicare spending.

In summary, rising spending will present serious challenges for policy makers and beneficiaries if action is not taken soon.

Today, the Commission will begin the process of making recommendations for payment updates in 2010. These payment systems are 50 percent of Medicare spending and any efforts that curb the growth of these systems will help the

sustainability of the program and reduce the burden for taxpayers and beneficiaries. Additional changes to Medicare will also be needed to control volume and improve quality. These policies, along with efficient payments, can help to drive the system improvements we need.

Medicare faces enormous near-term fiscal challenges and action needs to be taken soon because the problem will get bigger if we wait. By beginning to take action today, we can reduce the burden that future policy makers will face as they wrestle with Medicare's fiscal challenge.

This completes the context portion of this presentation and Jeff will now brief us on our framework for assessing payment adequacy.

DR. STENSLAND: So Evan has discussed the fiscal challenges Medicare faces and how update decisions affect the financial viability of Medicare. So now I'm going to shift gears and review the framework that the Commission has used to guide its deliberations on the adequacy of Medicare payment.

By statute, MedPAC is required to annually provide Congress with recommendations on how to update Medicare

fee-for-service payment rates. These recommendations provide important guidance and support for Congressional decisions regarding Medicare payment. Later today, the Commission will deliberate on whether current payment rates are adequate and discuss how much payment rates should be increased in the following fiscal year. In general, the staff presents data on the adequacy of payments and how costs are expected to change. The Commission then deliberates and makes recommendations.

Historically, the Commission has looked at these six factors when evaluating if payments are adequate. However, there is nothing formulaic about the update recommendation, and ultimately the update decision rests on the collective judgment of the Commission.

In the past, the staff has always presented data on the aggregate payments going to each sector and the aggregate costs in each sector. The Commission could then evaluate the relationship between Medicare payments and provider costs and look at the average provider's Medicare margin. The Prescription Drug Improvement and Modernization Act of 2003, the MMA, required that the Commission consider the costs of efficient providers when making update

recommendations.

Bearing this in mind, we are in the process of expanding our in data gathering methods to include identifying and reporting on a set of providers that look relatively efficient. This year, we plan to examine relatively efficient hospitals, meaning hospitals that tend to perform well on quality and cost metrics. In future years, we expect our efforts to evolve into examining the relative efficiency in other sectors. However, we will be limited by the absence of cost data in some sectors and this process will take some time to evolve.

When evaluating quality, we look at metrics such as mortality and readmissions. Eventually, we would like to know the degree to which a hospital contributes to the overall efficiency of the system. We want to know the risk-adjusted annual cost of care for patients served by a specific hospital's physicians. I think this is what some of you have referred to as longitudinal efficiency. However, we do not yet have this data that ties the annual risk-adjusted cost per potential beneficiary to a specific hospital.

Therefore, we are currently limited to identifying

hospitals that are able to produce good outcomes while keeping costs per discharge low. This could be termed per unit efficiency. Eventually, as the data becomes available and risk adjustment methods improve, we may be able to move towards reporting on a broader definition of efficiency where a hospital and its affiliated physicians are judged not just on the outcomes and cost per admission, but also on the team's ability to prevent unnecessary admissions.

To sum things up, we have always presented data on the costs and margins of the average provider. The one change going forward is that we will start also presenting data on the costs and margins of relatively efficient providers.

Currently, relative efficiency refers to quality metrics and per unit costs of the provider. In the future, our concept of efficiency may be expanded to examine system efficiency over the course of a year.

Now we will open it up for your comments.

MR. HACKBARTH: Thank you Evan and Jeff. A couple of comments. I just want to underline what Jeff just said about the term efficiency. This is directed as much to the audience as to the Commissioners. To some ears, when they

hear the term efficiency, they think that's synonymous with cost. We are only focused on cost. That's not the way we're using efficiency here. We are trying to take into account both the cost and the quality of the service being produced. And so I will emphasize that at various points in the conversation.

The second thing is that this is a good introduction to the update discussions. We've got a lot of specific sectors to cover, so I want to limit the conversation right now on this presentation to just questions of clarification.

As a reminder, as we proceed through the discussion, we will use our three-step discussion process. Round one is questions of clarification. Round two is an opportunity for every Commissioner to make an initial comment or question. And then round three, as appropriate, we will try to focus the discussion on some particular issues that seem important. For this presentation, we are just going to round one, questions of clarification, so we can get into the meat of the presentation.

Any clarification questions? Well, I succeeded in discouraging that, didn't I?

Okay. Good job. Thank you for setting the table for us.

Let's now turn to the hospital update discussion.

DR. STENSLAND: This session will address the adequacy of Medicare payments to hospitals. You will be deliberating on the update recommendations for both inpatient and outpatient hospital payments.

Before we start, I would like to thank several people: Tim Greene, Dan Zabinski, Zach Gaumer, Hannah Neprash, and Julian Pettengill all contributed to the analysis that you will see here today.

When evaluating the adequacy of hospital payments, we examine whether the aggregate amount of money paid to hospitals, including both inpatient and outpatient payments, is sufficient. In 2007, Medicare spent roughly $136 billion on traditional inpatient and outpatient fee-for-service payments. This represents over 30 percent of Medicare spending.

Each year, the Commission deliveries and make a judgment as to the adequacy of hospital payments. Today, you will discuss fiscal year 2009 payments and determine whether they are adequate, taking into consideration

indicators of payment adequacy you see on this slide.

In addition, the MMA requires that MedPAC consider the cost of efficient providers, as I just mentioned.

We will first discuss the data in each of the payment adequacy indicators you see here. Then I will discuss the process we use to identify hospitals that appear to be relatively efficient given their quality and cost metrics.

As an indicator of access, we monitor hospital openings and closings. In that 1990s, far more hospitals closed than opened, but in recent years more hospitals have been opening than closing. In 2007, 37 PPS hospitals opened and 21 PPS hospitals closed. Most closures were in urban areas. However, there were two rural PPS hospital closures and five rural critical access hospital closures. Both PPS hospitals closures and most of the CAH closures were within 20 miles of another hospital.

Another indicator of access is whether providers are expanding the list of services they offer. We find that the list of specialized services is growing with more hospitals offering advanced imaging, trauma services, cardiac services over the recent years, but we do see a

decline in hospitals offering psychiatric services. In future years, we plan to look further into the psychiatric service Medicare payments.

Our final indicator of access is the volume of Medicare services per beneficiary. As more services can be performed on an outpatient basis, we see rapid growth in outpatient services per beneficiary. That's the green line shooting upward you see. This indicates that access to care remains strong. Now, you may expect to see inpatient volume per beneficiary declining as services shift from inpatient to outpatient. However, despite the shift of some services to outpatient, inpatient admissions per beneficiary remain relatively flat.

Now we switch to looking at the quality indicator. The quality of care indicators are generally improving. We see improvements in hospital and 30-day mortality for the eight conditions we monitor. We also see improvements in five of the eight patient safety indicators we monitor. The remaining three had no significant change. The Joint Commission recently reported that all of the process measures they track improved from 2002 to 2007. For example, the share of certain AMI patients discharged with a

beta-blocker prescription increased from 89 percent to 94 percent.

The next payment adequacy indicator is access to capital. As we showed you last year, access to capital was strong through 2007 and construction was booming. We were at a record high level of construction last year. However, access to capital has been erratic in 2008 and access to capital has been tightening in the fall. Bond offerings and construction started off at a record pace in January, but that they froze up in September 2008 due to an economy-wide freeze in the credit markets. By November 2008, health care bond offerings had made somewhat of a comeback with over $3 billion of bond offerings. However the interest rates on these offerings were roughly 2 percent higher than in 2007. Interest rates now for a AA or A rated hospital appear to be in roughly the 6.5 to 7.5 percent range.

Because the dramatic changes in the credit markets were not caused by changes in Medicare payments, changes in access to capital in 2008 may not be a good indicator of Medicare payment adequacy.

Now we will shift over and Craig will talk about changes in Medicare margins.

MR. LISK: I'm going to talk about our Medicare margins and the most recent data we have and our forecast for 2009.

Our margin is calculated as payments minus cost divided by payments and are based on Medicare allowable costs. The overall Medicare margin, which is a measure we use here on the top line, covers acute inpatient, outpatient, hospital-based home health, and skilled nursing facility, and inpatient psychiatric and rehabilitation services in hospitals covered by the inpatient prospective payment system plus graduate medical education expenses.

The overall Medicare margin has trended downward since 1997 and has been negative since 2002. From 2006 to 2007, the overall Medicare margin fell from minus 4.7 percent to minus 5.9 percent. As you can see, the inpatient margin has also fallen over this period, while the outpatient margin has held relatively steady.

This next slide shows how the overall Medicare margin differs across hospital groups. A number of payment policies and conversions of poor performing rural hospitals to become critical access hospitals have helped push the rural hospital margin above urban hospitals in 2007.

Historically, rural hospitals had lower Medicare margins than urban hospitals. Major teaching hospitals continue to have overall Medicare margins that are much higher than the average PPS hospital, in large part due to the extra payments they receive through the indirect medical education adjustment and the disproportionate share adjustments.

Critical access hospitals are not included in our margin calculations as they are paid 1 percent above costs for inpatient, outpatient, and swing bed services. Critical access hospitals, however, account for over half of all rural hospitals and about a quarter of all Medicare revenue going to rural hospitals. If we included critical access hospitals in our margin calculations for rural hospitals, the rural hospital margin would be minus 4.2 percent.

Next, we move on to discuss where we think margins will be for 2009 given 2010 payment policies. We estimate that the overall Medicare margin in 2009 will be minus 6.9 percent, one percentage point lower than in 2007. Our projections reflect the effects of policy changes occurring between 2007 and 2009 as well as 2010 payment policy changes other than updates. On the next slide, I will summarize what these payment policy changes are that affect these

margins.

In our margin projections, we assume that payments will increase for many rural hospitals as sole community hospitals will be able to use a more recent 2006 hospital specific rate for determining their payments. Sole community hospitals account for 46 percent of all rural hospitals under the IPPS payment system. We also believe that payments will also increase from changes due to coding practices due to implementation of the Medicare severity adjusted DRGs, or MS-DRGs.

A number of payment provisions, though, will result in lower margins. Payments will be decline from two capital payment provisions, the elimination of the 3 percent urban add-on in 2008 and the phase-out of the capital IME adjustment in 2010. The sunsetting of Section 508 reclassifications, which allowed for certain hospitals to increase their wage index, will also result in a reduction in Medicare payments for certain hospitals. IRF payment rates were also held flat between 2007 and 2009.

Likely the biggest factor putting downward pressure on Medicare margins is cost growth, which we expect will continue to increase faster than input price inflation

in payment rates from 2007 to 2009. Our analysis assumes per case costs will increase about 4.1 percent per year.

DR. STENSLAND: Craig has just showed you how margins have been declining as cost growth has exceeded payment updates. This may raise the question of why has cost growth exceeded the updates? One of the factors is that when private payer profits are high, cost growth tends to be high. Hospital profits on private payer patients have gone through three periods over the last 15 or so years. They rose in the 1980s. They fell in the mid-1990s. And now in recent years, they have risen back up to a record high. In 2007, private payer payments were roughly 132 percent of costs, on average.

The message I'm trying to get behind this slide is that because hospitals' profit margins on privately insured patient have been growing, they can afford more cost growth. And as you know, more cost growth leads to lower Medicare margins.

On the right-hand side of this chart, you see hospitals with high non-Medicare profits tended to have high costs and low Medicare margins. Now, of course, not all providers have high private payer profits. Some providers

out there are struggling. Some hospitals are under financial pressure to control their costs.

On the left-hand column in this slide, we see that hospitals under a high level of pressure to keep their costs down did have lower costs, but as they have lower costs, they have higher Medicare profits.

In this slide, we are roughly saying that hospitals with a margin less than 1 percent and stagnant or declining levels of net worth will feel pressure to constrain costs. In the years after they feel the pressure, these hospitals kept their costs down to a standardized amount of $5,800 per discharge, on average. Those not under pressure had costs of $6,004 per discharge, more than 10 percent higher. The lower costs of those under pressure contributed to their higher Medicare margins.

We can see that hospitals can constrain costs, but this may raise the question of can they constrain their costs and maintain a high level of quality?

This brings us to looking at the issue of hospital efficiency, which we discussed as we kicked off the meeting this morning. This year, we are exploring identification of relatively efficient hospitals. Ideally, we would want to

know the degree to which a hospital contributes to the overall efficiency of the system. We would want to know the risk-adjusted annual cost of care of the patients served by a hospital's physicians. However, as I mentioned this morning, this data is not currently available. Therefore, we are limited to identifying hospitals that are able to produce good outcomes while keeping costs per discharge low. This could be termed per unit efficiency.

To identify a set of relatively efficient providers, we use the following criteria. First, the relatively efficient hospital must excel on at least one measure. This means either they have to have risk-adjusted mortality or risk-adjusted cost that is in the best one-third of all hospitals in every year from 2004, 2005, and 2006. In addition, we require these efficient hospitals do not perform poorly on any measure. This means that risk-adjusted mortality, remission rates, and costs must all be at least in the middle third or the top third in every year.

Now, the criteria that I'm using is fairly strict because any hospital with high costs in one year or poor quality in one year is dropped from the efficient group.

After we screen the hospitals based on their mortality scores, their remission rates, and their costs, we ended up with a group of 338 hospitals that appear to be relatively efficient providers, at least on a per unit of production basis. This represents about 12 percent of the PPS hospitals in our sample.

In general, we find that hospitals that appear to be efficient in 2004 to 2006 were able to outperform the comparison group on all mortality measures in 2007. For example, using the AHRQ composite mortality measure, the relatively efficient hospitals had a mortality rate that was 14 percent below the median hospital's risk-adjusted mortality rate. While not shown on the side, we also examine mortality measures using the CMS Hospital Compare database. We found that the efficient set of hospitals outperformed the comparison group on AMI, CHF, and pneumonia, all three of the CMS risk-adjusted mortality measures. We also see that this set of relatively efficient providers is able to achieve lower mortality while keeping standardized cost per discharge 11 percent below the national average. Lower costs allow these hospitals to break even on Medicare.

We also examined how the hospitals appeared relative to each other using the metric of patient satisfaction. We found that 63 percent of patients rated their hospital either a nine or a ten on a ten-point scale. This is for both the efficient group and the comparison group. This suggests that patient satisfaction between the two groups did not differ.

In summary, most of the payment adequacy indicators are positive. However, Medicare margins in 2007 were low and they are expected to decline further. While most hospitals have negative Medicare margins, the distribution of Medicare margins varies widely. In our examination of hospital efficiency, we identified a set of hospitals that consistently maintained low cost, low mortality, while breaking even on serving their Medicare patients.

Given the data presented to you today, the Chairman has decided to have the initial draft recommendation be the same as last year's recommendation as a starting point. It reads, The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2010 by the projected rate of

increase in the hospital market basket, concurrent with implementation of a quality incentive payment program.

Now, recall that in addition to making recommendations on the level of Medicare payments, the Commission has also made recommendations on the distribution of payments in the past. Last year, the Commission recommended that the pay-for-performance program be funded with a reduction in indirect medical education payments. Craig will now give you some background on last year's IME recommendation and discussion.

MR. LISK: The IME adjustment is a percentage add-on to the PPS rates. It varies with the number of residents a hospital trains.

In 2007, IME payments to hospitals totaled about $6 billion and went to 30 percent of hospitals. The current IME adjustment, however, is set more than twice the documented impact of teaching on hospital costs. The current adjustment increases payments by 5.5 percent for each 10 percent increment in the resident-to-bed ratio. Analysis we conducted for our 2007 March report, however, showed that the inpatient costs in teaching hospitals increases 2.2 percent for each 10 percent increment the

resident-to-bed ratio.

Having the IME adjustment set considerably above the true cost relationship contributes substantially to the large disparities in financial performance under Medicare between major teaching and non-teaching hospitals.

In 2007, the overall Medicare margin for major teaching hospitals was 10 percentage points are then for non-teaching hospitals. However, this gap will be reduced slightly due to the elimination of the capital IME adjustment, and the gap will narrow by about a percentage point. If the Commission adopts its recommendation as it previously had for reducing the IME adjustment to 4.5 percentage points from 5.5, the gap will narrow by about two percentage points, as well, and using them money for P4P.

Even with adoption of these two sets of policies, though, the gap will remain as IME payments will still be larger than the empirical amount and teaching hospitals would continue to benefit from having on average higher DSH payments, as well.

Teaching hospitals was also likely benefit from the adoption of severity adjustment with the introduction of the MS-DRGs in 2008. This potentially could result in a

widening gap of the financial performance, but right now we don't know what that will be until we actually have data on MS-DRGs.

So the chairman is proposing that we include the same recommendation we included in last year's report for reducing the IME adjustment and using the funds from this to support a quality incentive program. The recommendation reads as follows: The Congress should reduce the indirect medical education adjustment in 2010 by one percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the IME adjustment should be used to fund a quality incentive payment program.

In terms of spending implications, because this is intended to be budget neutral, there would be no spending implications on this recommendation and it would narrow the disparity in Medicare margins while making funds available to reward high-performing hospitals, potentially improving quality for beneficiaries.

And with that, we would be happy to answer your questions.

MR. HACKBARTH: Good job. Thank you. When we get

to the discussion, I'd actually like to invite a discussion of a modification of draft recommendation two, as opposed to using the IME money to enhance funding for pay-for-performance. An alternative that I think we ought to consider is taking that IME money and putting it back in the base rate. The reason I think that's worth at least some discussion is, you will recall from the data there is a large disparity in average margins between the teaching and non-teaching hospitals. The non-teaching was minus 9.3, as I recall. And so I think we ought to at least talk about using the reduced IME expenditures to increase the base rate, which would provide some assistance to those non-teaching hospitals.

So we'll do our three rounds of questioning. Round one is questions of clarification.

DR. KANE: I have three questions, but one is quick. Was that the IME reduced by some amount already, or are we still just trying to get the first reduction?

MR. LISK: No, what happened is that the IME adjustment is at 5.5 percent. There was a slight change from 2007 to 2008. That actually was a slight increase, a very slight increase. And then the IME reduction really

that is taking place is the Secretary is eliminating the capital IME adjustment, so that's the reduction. The operating IME adjustment has not changed, and that's still set for 5.5 percent.

DR. KANE: The other question is does the market basket reflect changes in costs that might be sensitive to changes in the economy, such as pension liability or malpractice expense that's driven off a premium that might be set based on how well your investments are returning? Is that captured at all in the market basket?

DR. MARK MILLER: Jim, you had this conversation with the actuaries?

DR. MATHEWS: That's correct. We did talk with them yesterday afternoon on this point and the current projections of market basket are very much done in real time and very sensitive to the changes that we are observing in the economy overall. Some of the projections are based on data as recently as the end of October.

DR. KANE: So if a hospital had to increase its payment into its pension fund because it lost market value, some of that would be reflected in the market basket?

DR. MATHEWS: That's correct.

MR. LISK: Actually, unfortunately, in terms of is going to be reflected in terms of economic trends, in terms of the underlying parameters that go into it. Some of that will ultimately be reflected. But in terms of that portion of hospital costs, I don't think there is a component in the market basket that reflects, let's say, pension liability in the market basket. Interest rates and those types of things are separate, but there's no specific component for that piece. But malpractice insurance is one that is in there, it is a specific component. So if there's changes in that, that type of change in terms of their costs would likely be reflected.

DR. STENSLAND: There might be a big difference between the hospital. If you have an old hospital with a big defined benefit pension plan, they might see the value of their pension assets shrink and they may have to really put in a lot of money to build that back up again, whereas a newer hospital that maybe doesn't have a defined benefit plan but just has a defined contribution plan wouldn't see any additional expenses.

MR. HACKBARTH: Just for my own clarification, so the change in the hospital's pension liability and the fact

that it may now, because of what happened in the stock market, have to start making more contributions, that's a change in its cost structure. It's not a change in the unit prices it pays for inputs, which is what the market basket is supposed to measure.

MR. LISK: That's correct.

MR. HACKBARTH: The malpractice liability, and that's something they purchase from the outside, and to the extent that the financial markets force the premiums up for malpractice insurance, that would be reflected in the market basket.

DR. KANE: Unless you're self-insured, or --

MR. HACKBARTH: Right. You're not buying that on the market. That would be an internal cost issue.

DR. MARK MILLER: What I think Jim is saying, though, is that at least for the forecast group that we get the projected market baskets from, they are taking the inputs into account as they go forward.

MR. LISK: Could I just clarify one --

DR. REISCHAUER: We aren't doing this hospital by hospital. This is one for the sector as a whole, so it is the average weight that is ascribed to that component.

MR. LISK: I just want to clarify, though. The market baskets you have on your little cheat sheets that you were given in terms of that you have on your summary sheets, those are market baskets that were produced in the third quarter of the year before the collapse in the financial markets and the current declaration of the recession that we're in, and so those numbers likely will change when we get a new forecast from CMS later this month and the indications are probably the numbers will be going, in terms of market basket forecast, they will probably be going downward because the recession.

MR. HACKBARTH: Peter, was it a clarification on this particular --

MR. BUTLER: Let me just clarify on this, because we have the specific in our own institution. The pension would not be in any of these forecasts, what we are talking about. And you're correct to say some have more defined benefit components than others. But in our institution, when the value of that portfolio went down, because some of it is in equities, that would not show up, and at the end of the fiscal year, when the actuary says, how much do have to fund next year, it would show up in next year's operating

expense and you would have a big spike up in that. There is no way you have any data to project that increase at this point in time.

With respect to the malpractice, it's also correct that if you are purchasing externally a premium to cover malpractice, that would be in your predictor. In our situation, because almost everything is self-insured, we have literally $160 million set aside. To the extent that that is in any investments that would go down in the market, which is the case, we have to immediately replenish that and it would show up in our cash and impact us. That would not be true for all hospitals, but it would be true for quite a few.

DR. KANE: Do I dare ask another question? The last one is on page six, I mean, on your sixth slide. When you are talking about access, yes. So the dotted line says outpatient service, and I'm presuming you're only including hospital-based outpatient services, not any of the freestanding. And if you're really thinking about access, don't you really need to have those close substitutes that just happened to be owned by different silo in there, like ASC or lab and imaging? Because access might be twice as

good as that if you including close substitutes. It's just a different silo but the same service substitutes.

DR. STENSLAND: That's a good idea. We could put another line in there next year. But we know what's happening to IDTFs and we know what's happening to ASCs, so we've got a big increase in hospital outpatient, and if you add those other things in there, then you're going to have a really big increase.

DR. KANE: But that might help us think more about it.

DR. REISCHAUER: This is just a clarifying question. When we do margins by hospital type, is that an average of units or is it weighted by Medicare expenditures?

MR. LISK: It's an aggregate margin, so it's --

DR. REISCHAUER: So it's the sum of all --

MR. LISK: It's the sum of all. It's not an average of what's in major teaching hospitals, for instance, because in the aggregate for all payments --

DR. REISCHAUER: Some of the data we have is sort of the unit is the institution as opposed to the beds, might be more meaningful.

MR. HACKBARTH: And that's true across sectors.

Our basic approach is to look at --

MR. LISK: That is correct.

MR. HACKBARTH: So in effect, it's weighted by the size of the institution.

MR. LISK: Correct.

DR. CASTELLANOS: First of all, good report. On IME, MedPAC is a prudent spender of taxpayers' money and one of the big concerns we've always had with IME is where is that money going and what's it being spent for. I know we've asked for better accountability. I was just wondering if there is any follow up on that.

MR. LISK: I think in part, and I don't know if Mark wants to take this, we are doing some other stuff on workforce and GME and IME coming up with the Commission in terms of some of those decisions about what we may decide to do with our funding for these things, too.

DR. MARK MILLER: Yes. The big problem with this is we don't have, if I understood your question, we don't have data that allows us to account how hospitals use that money. Once it hits the hospital, it just becomes money. And several years ago, Glenn and I had some conversations to see whether such data could be found and how the teaching

hospitals, what they would feel about that, and there was a fair amount of difficulty in trying to figure out how to do that. At this time, we don't have an ability to account for it. And you raise a point that has consistently come up here. What does happen to it? And hospitals say they use it for very different things as you talk from hospital to hospital.

MR. HACKBARTH: Okay. We're still in the clarifying round.

DR. MILSTEIN: Could you clarify whether or not in our last year's recommendation, in which as I understand it we did not recommend subtracting a productivity adjustment from the market basket recommendation, why we didn't recommend subtracting a productivity adjustment?

MR. HACKBARTH: Do you want me to take that? Our basic starting point is to look at the market basket and then a productivity expectation, and for the new Commissioners and people in the audience, the productivity adjustment is an expectation. We are not trying to measure, and you know this, Arnie, we are not trying to measure the actual productivity change in a particular sector but rather say that the people who fund the Medicare program are under

market pressure to improve productivity and we think similar expectations ought to be made of health care providers financed through Medicare.

In the case of hospitals, last year we recommended a full market basket without the productivity expectation plus some other things like the IME change. The reason for that was based on the fact that the average margin was already very low, and so we elected not to add the additional expectation of productivity. So that was the basic thinking last year.

Jack?

MR. EBELER: We did include in that recommendation, as the draft recommendation one reflects an reflects, an offset for pay-for-quality piece off of the market basket.

MR. HACKBARTH: Thanks, Jack, for mentioning that. What we said was we thought the size of the pool ought to be increased by a full market basket, but then the distribution of dollars would be affected by the pay-for-performance component, which as you know, Arnie, we've recommended to be funded out of across-the-board reduction in base rates of 1 to 2 percent and then redistributed based on quality

performance.

So even with a full market basket increase in the size of the pool but guaranteed update for the hospital, it would be less than full market basket. How much they got would be contingent on how they performed on the quality scores.

DR. CHERNEW: I have a question about the statistics on entry and the building boom stuff that you presented. Is that at all segmented or segmentable by dimensions, like teaching and non-teaching hospitals, for-profit and nonprofit facilities, or in places with high Medicare versus low Medicare share areas, areas with high or low Medicare efficiency?

DR. STENSLAND: Last year, we went through an exercise where we tried to go and discover where is all this building going on. We kind of had this assumption, was you hear these kind of modern health care kind of stories. It's all in the suburbs and they're fleeing the inner-city and going to the suburbs. But when we looked at the construction permits that we got -- we got construction permits by county, at least, and it seemed like it was going pretty much everywhere, even in the areas where they were

high Medicare or low Medicare, higher income, lower income, higher Medicaid, lower Medicaid. You know, there was a little chance to the duration expect a little of your little bit of shift in the direction you would expect, a little wealthier, a little more construction, but it was pretty widespread across the whole country.

DR. CROSSON: Thank you. My question was the same as Arnie's. It must be that the California people are waking up at about the same moment.

[Laughter.]

DR. CROSSON: But I assume that, although you didn't say it in your comments, that the same rationale for last year is being applied to this recommendation.

MR. HACKBARTH: But, of course, the reason we're here is to discuss whether in fact we want to make that, but that's what I'm recommending as a starting point.

MR. GEORGE MILLER: In your numbers for rural, were rural referral centers included in your margin calculations and --

MR. LISK: Yes.

MR. GEORGE MILLER: What would be the impact if they were not included for rural hospitals?

MR. LISK: I'd have to get back to you on that, but the rural referral hospitals were included in the margins calculations.

MR. GEORGE MILLER: I guess intuitively, I would think they would have higher margins so wouldn't that --

MR. LISK: Actually, their margins actually were minus 4.5.

DR. STENSLAND: The odd thing about the rural margin now is it's kind of been turned on its head. If you would have asked us ten years ago which rural hospitals have the poor margins, it would probably be the little rural hospitals that had the poor Medicare margins. But now the little rural hospitals are some of those with the better Medicare margins --

MR. GEORGE MILLER: Are you talking about critical access hospitals or non-critical?

DR. STENSLAND: No, the rural. The small rural PPS hospitals are some of the better margin PPS hospitals, and the reason being that all those little rural hospitals that were losing money all became critical access hospitals. So the ones that are left are the ones that were doing pretty well under PPS. That's why they didn't convert. So

the small little ones are really actually looking pretty good relative --

MR. LISK: The under-50-bed, we show minus three, so relatively speaking they're better.

MR. HACKBARTH: Okay. So we're finished with round one clear clarification questions. Let me see hands for people who would like to do round two initial comment.

DR. BORMAN: My comment would build on one of the clarifying questions that was asked. I would wholeheartedly support the notion that we really have great difficulty in understanding where IME dollars go when they reach a teaching system, and that's not good and that is not responsible to the people who are on the receiving end of the dollars. There should be accountability for that. Certainly the beneficiaries and taxpayers deserve that.

Having said that, however, not knowing where that money goes, understanding the wide range, or the extent of the menu to which some of those things that may go, the importance of that money in some of the teaching centers, particularly at the lower end of the receiving spectrum, I'm very concerned about taking that money away without knowing where it goes a little better, and I would like to

potentially see this attached to some renewed effort to demand that those kinds of data be collected.

I think the whole issue of workforce and what our system will look like, not necessarily just the physician workforce, but where we want to go to is so -- in such degree dependent upon the pool of people we have it to populate and deliver quality care that I really think that we need to demand accounting about this a bit.

I would raise the technical question, and Peter may in fact know the answer, but certainly in my own specialty world, roughly half the teaching programs are in university-based medical centers and roughly half are in non-university-based. At least in my program director world, those institutions that are running training programs without a university are increasingly reevaluating the value of continuing to sponsor those programs, suggesting to me that they are under some pressures that maybe aren't being measured here.

Now, perhaps that's some sort of isolated phenomenon in general surgery. I don't know. But I would wonder if we might have a way to just make one attempt to drill to the answer to that, because will this particular

thing again disable a particular group? And I would point out that at least in my world, individuals who complete their residencies in those programs have a somewhat higher likelihood of going to some what smaller size communities and delivering a broader range of services rather than ultra sub-specialization in very large communities. So that could be an important question to answer.

And then my last sort of question and comment would be relative to where the money would go were we to advocate this. I recall some discussion, and one that I'm somewhat more comfortable with than the current recommendation of where it goes, about potentially using this to set criteria that would that be met by the hospitals that receive the IME and to perhaps become leading-edge purveyors of care. That is that you don't get your IME or all of your IME unless you achieve a certain level of EMR implementation, or whatever it might be. I think we discussed a number of other things.

And so why we're going in this direction as to potentially that direction would be of some interest.

MR. HACKBARTH: I respect the queue, but Karen has made two critical points that I don't want to just let go

by. The issue of accountability for how the money has been used, as Mark indicated, is something that we've talked about for years now. In concept, it's a good idea. The problems are practical problems. These dollars go into the hospitals' general fund, and once they're in the general fund they don't have IME labels on them. They're just bits on the computer. And money is fungible. So it literally is not possible to say, well the IME dollars were used for this and Aetna's dollars were used for that. They're in a general fund.

Now you could, as you suggested later on in your comments, say the only way you get the IME dollars is if you meet certain tests. It's contingent on your doing certain things. And so before the dollars go into the hospitals' fund, they have to pass through a gate. That is an approach that conceptually I think you could work out. But once they're in there, saying what were they used for, you just end up chasing your tail.

DR. BORMAN: I guess I would support in our thinking some up-front or preemptive methodology or requirement, if you will, to begin to demonstrate, and there might be a list of activities that could be developed to

measure as are these projects or processes or activities that are in fact going on that we can identify are high-quality education activities.

MR. HACKBARTH: I think that path, a couple sessions ago we had the session on medical education training and that panel made some proposals about making availability of IME funding contingent on certain sort of programmatic activity. So we will come back to that.

MR. BUTLER: I will take maybe slightly longer than I normally would just because of particularly the IME issues, but let me make first some general comments. One, a very positive thing. You've highlighted some of the quality improvements and I think that they're not insignificant. I think hospitals both are increasingly embracing and supportive of tying payment to performance on quality and satisfaction. I think we're making some darn good progress on that front and we ought to keep pushing that for sure. So that's the very positive thing.

I think what we also have to recognize just in general in hospitals and in all of Medicare and in all of the economy, we are in uncharted waters here and we are tweaking payment systems here in the next couple of days

when dramatic events could reshape everything that will overwhelm some of these things. Just as you look at market basket and so forth, just in the last two weeks, and as recently as yesterday, both Moody's and Fitch's have had a negative outlook on the entire hospital industry and it is not just the cost of debt. It is reductions in volumes. It's increases in charity care. And again, that's not a Medicare per se issue, I recognize that. But I think we're going to see some dramatic changes.

I don't know a single colleague in a hospital that has not revisited their capital spending right now and either delayed, deferred, or eliminated or not started projects. Many are completing projects, but virtually every institution -- so even the capital thing, you're going to see a dramatic change in the landscape of capital spending, I would predict.

There's a saying, you can drown in a lake that's an average of five feet deep. So as we look at these averages, I think what we also don't know about is the stimulus package and everybody and his brother is going to be at that trough saying, I need some of that, and I can easily see how -- hospitals included -- saying I need some

of that to stay alive. So it will be an interesting time.

Having said that, I can support the market basket proposal that's on the table, but I obviously would like to comment on the IME.

Now, my understanding, not having been on the Commission, part of the reason for the initial recommendation for the reduction was tied to the expectation that MS-DRGs was going to perhaps help the teaching hospitals more than some others, at least that's my understanding of the history. All I can say, in our institution, that hasn't been the case. The MS-DRGs have not helped our payment. It's kept it the same in terms of the coding and kinds of issues. That's just an aside.

Now, if I could turn to page 21, one back from here, just to clarify what we're talking about. The reduction we're talking about really is three percentage points all together if you take the capital IME that has been put in place, right?

MR. LISK: It's actually a little less than one percentage point.

MR. BUTLER: It's approximately 3 percent if you include the capital IME. This specific recommendation would

have approximately a 2 percent, on average, impact on teaching hospitals right?

MR. LISK: Yes.

MR. BUTLER: Which is the 2 percent is about, by the way, a 20 percent reduction. It's not a 2 percent reduction, it's a 20 percent reduction in the IME, because 5.5 to 4.5 is roughly a 20 percent reduction in the payments for IME, which is significant.

Now go back to slide 11. This is just factual, just so people understand. If you look at the 1.1 percent margin on major teaching hospitals -- and some would argue that that's highly stated because, for example, there are about 5,000 residents that are over the caps for which there is no payment and the full costs are being absorbed by the teaching hospital -- but anyway, let's assume that the 1.1 percent is what it is. What the implementation would mean is that we would go to -- and you can correct me if I'm wrong -- 3 percent less than that. If you include the impact of the capital IME, you would be negative 2 percent margin for the teaching hospitals.

If that were the case and you were to just exclude all the rest and say, let's act on this one alone, would we

say that it's the right thing to do in our updates to take major teaching hospitals this time into a 2 percent negative margin would be one way to look at this. Is that --

DR. STENSLAND: But it would bring the others up. This is not taking money out of the system. It is just redistributing it.

MR. BUTLER: I'm just saying, ignore the others for a minute. I realize you're shifting money. No, I understand. It is shifting money, but if we were to only act on the teaching hospitals, you are saying taking them into negative territory would be a recommendation in effect.

MR. GLASS: Well, they may also get some back if the quality P4P is up, presumably teaching hospitals, if they are higher quality, they will get more.

MR. BUTLER: It depends which recommendation you take and it depends on whether that -- I'm just looking at the numbers and what we're talking about here. It is a 20 percent reduction in IME and also almost 30 if you take into account the capital IME. Okay.

MR. LISK: The capital IME, though, is about -- it rounded to six, but it's about 6 percent actually of the total IME payments, just to say. So it would be about 25

percent.

MR. BUTLER: So then the last -- this is to get the facts on the table. The two things that I would additionally point out, and one I will say quickly and then won't dwell on, that the total margin still in major teaching hospitals remain lower then other hospitals. And I realize we're talking about Medicare only and so I'll drop it at that. But it is a factor if you want to look at the overall financial health of teaching hospitals.

And finally, I'd say that I think it was referenced by Karen some, when you look at what is going on in the university, the medical school side, with endowments and support for research, it is all part of the economic web of teaching hospitals. So to the extent that university endowments are largely impacted, it spills right over into the financial pressures of the academic medical center campus. Again, that's not Medicare per se. I'm just pointing it out. It is part of the economic health of the academic medical center environment.

And for us, because we have our medical school as part of our same corporation, it's right in our economics. So when our endowment has been going down 20, 25 percent

like most, it has a direct impact on 25 percent less money being able to support research. We have to factor that into our overall budget. Again, I understand that's not Medicare. I'm just commenting on the impact on the economic health of the academic medical centers over all.

MR. HACKBARTH: Just to sum up that, what I think I heard Craig and company say is your rough arithmetic is correct. The policy issue is what do you focus on, the fact that you're taking teaching hospitals from a positive to a negative, or that you're reducing the disparity among them. So that's a discussion that we need to come back to.

MR. BUTLER: If I could make one last comment, I know I've had my share of air time here, I do support, and I've said before that the formula is a weird thing in the way the whole thing is handed out. And to the extent we need to further reform and incentivize GME to be responsive to the environment that we need to practice in, I am highly supportive of that. I'd rather have things tied more to that than some of the proposals on the table.

MR. HACKBARTH: Fair enough, and people do need to think about that, that at some point down the road we may want to say, well, we want this pot of money targeted for

specific training and other goals, and if it's put back into the base, then it's not available for that. So some important policy questions have been raised.

DR. CASTELLANOS: I wonder if you could put slide 15 on, and Jeff, this is really kind of directed towards you. You remember last year you are able to help me quite a bit when we talked about physicians, the ones at high quality, low cost, and then there's high quality, high cost. But this slide really intrigues me. Why do the high-pressure hospitals, the ones with low non-Medicare margins, are able to have positive Medicare margins? That group of hospitals has got to be doing something different.

Do you remember when we drilled down into the physician community we found out that group of physicians really had a better working relationship with the administration. I am just wondering what separates this hospital. What are they doing different than the medium or the low-pressure hospitals? And I wonder if we could drill down on that subset.

DR. STENSLAND: Last year, what we had was some anecdotes from site visits, because we went through this process, and we didn't look at specifically these low-cost

ones, but we looked at hospitals that had low cost and high quality metrics. The anecdotes from the site visits, where they often had -- they had good relationships with their physicians. Whether those were employed physicians or independent physicians, they had good relationships where they thought they were on the same page.

All of them ran pretty lean ships. They didn't have a lot of extra beds sitting around. They didn't have some of the nicer amenities that we have seen in some of the lobbies that we walk into in some hospitals. And I think all of them, they tend to have -- when they're under pressure, they tend to reduce their expenditures. And I guess we can't say every which way that they do it, but there is some reduction in expenditures. And some of them we visited, too, ended up operating at a very high capacity. That makes a difference, too, whether you're operating at a high capacity or whether you have a lot of vacant space in your hospital.

DR. CASTELLANOS: Do you think there's something we could learn from this, that the whole hospital community could learn and the physician community could learn?

DR. STENSLAND: We could go through it. It would

be a whole other exercise. We have to decide if we want to put that on the agenda as another project. It would be more of a qualitative project to match up with the efficient provider.

DR. STUART: Just a clarification on this, and I think there is just a lot of confusion in terms of what that margin means. If you go back, the denominator on the margin, as I understand it, is Medicare allowable cost, is that correct?

MR. LISK: Yes.

DR. STUART: And then the numerator is --

MR. LISK: Well, no. It's actually payments minus costs -- I mean, it's cost minus payments --

DR. STUART: Okay. But the numerator on that is going to be patient margin. It's going to be patient-related margin, is that right? Patient-related payments?

MR. LISK: Yes.

DR. STENSLAND: [off mic] So the numerator is profit and the denominator is your payments.

DR. STUART: Well, and it gets back to major teaching hospitals, too. It's really an accounting issue. I mean, if you were to look at all of the cash that comes

into a hospital that's available to purchase goods and services and capital and what not, and then all outlays, you'd get a very different measure of the health of the organization.

So it's absolutely true that if pension obligations are going down because of the market, it's also true that organizations that had large endowments, that endowment income is not considered patient income and doesn't show up in the statistics here. So depending upon the nature of the financing of the hospital, that margin could be high or low and it would really have nothing to do with what the Medicare part is doing. Is that correct? In other words, if somebody had a large endowment and was spending money from that endowment and the resources that were used were used for Medicare patients, that would increase the cost portion but it wouldn't change the revenue portion. So it would make the margin look lower.

DR. STENSLAND: And that's why when we look through the pressure analysis, it's not only your -- it's your income from non-Medicare sources and the change in your net worth. So basically what we're saying is if you're in a hospital and you're making a lot of money off your private

payer patients, you tend to spend that money, and when you spend that money, Medicare margins go down. Or if you're in a hospital where you get some big contributions from somebody, somebody makes a couple hundred million dollar contribution to your hospital, you tend to spend it. When you spend it, Medicare costs go up and the Medicare margins go down.

So you'll see this relationship. It's probably not a random event that this past year in 2007 was the year of the record all-time high in private payer margins and the low in Medicare margins. So these things are related, but they kind of move inversely.

MR. HACKBARTH: I want to get Bob in here really quick.

DR. REISCHAUER: I think you actually have answered my question. Last year, I asked whether we could do a correlation between Medicare margins by type of hospital, you know, teaching, non-teaching, et cetera, and the fraction of the hospital's business that is Medicare plus Medicaid, because in a sense, you do what you can do. And if you have limited resources, you tighten up somehow and then there are hospitals for which obviously Medicare or

Medicaid is a very small fraction of their business and so they aren't going to get that as a huge determinant of their behavior with respect to cost control. Did we ever do that?

DR. STENSLAND: We do see that. If you look at the characteristics of those that are under pressure to control their costs that have low non-Medicare profits, they tend to have more Medicaid patients. So we do tend to see that the hospitals that tend to have more Medicaid patients have lower costs and then have higher Medicare margins.

MR. HACKBARTH: Okay. We are still in round two and we've got about 15 to 20 minutes in this session and I want to make sure we get everybody in.

MR. BERTKO: Yet another follow-up question to this line of questions here, if you turn back to slide ten, you show a deterioration in margins and then there's another slide that shows further deterioration expected for 2009. My recollection from being on the Commission for a couple of years is that we were mostly paying either updates that actually occurred or update minus productivity, is that right, more or less?

MR. LISK: Yes.

MR. BERTKO: So what explains the deterioration?

I mean, in some ways it seems like we're recommending Medicare pays its own way. Craig, I heard you just say a moment ago about 2007 is explained possibly by that highest ever private sector margin. Any other comments on why the margins have decreased?

MR. LISK: It's mostly due to cost growth being greater then market basket. There is some where whatever was given as input price inflation was -- the market basket was in error, so there was a little bit of difference there that explained some of it. But mostly, even if you control for that, you see input prices rising faster than costs over the past five-year period, even case mix adjusting that. So that --

MR. BERTKO: So it almost seems that in spite of what Medicare contributes, the margin question for Medicare margins is unrelated to what we pay.

MR. LISK: In some, because of how the private sector has contributed. I mean, we actually see Medicare margins going down. Jeff talks about the private payer, but if you look at the total line for the hospitals in terms of total revenues and total margins, you actually see that total margins have been going up. So the hospitals have

been able to afford, on average, to sustain the lower Medicare margin because of that, essentially.

DR. CHERNEW: Thank you. I first want to say something quickly about the IME discussion we've had and then make one other comment.

On the IME discussion we had about where does the money go, what is it used for, I think there's two ways to think about that. One is sort of an accounting sense, and I think Glenn very well pointed out that that's not that fruitful for a number of reasons because of fungibility.

But I think part of the question that I have in my mind which I don't answer for is as we change the IME payment, or payment overall for that matter, what do we lose, or in this case lose, or what do we gain, and I think that is really what matters in terms of what you're getting for the money. Not where it looks like that dollar was being spent, but how once the hospitals or whomever adjusts however they adjust, what was the behavioral thing that we gained or lost? I think more information on that would be useful to know as we've changed IME. How have hospitals responded one way or another?

What I will try to say as a related comment,

although you may decide at the end it wasn't, we have spent a lot of time talking about margins. I recognize that margins are important and I don't want to diminish their importance in some ways. But we have spent virtually no time talking about what to make of all of the other indicators that are included in the chapters and margins are just one portion of them. So I understand that there is a Medicare margins versus a total margin, and I understand there's accounting issues with the margins, so you may or may not fully believe that is what the margins are. But there is somehow, I think, that the paradigm of trying to track payment on an accounting basis primarily misses some of the other things that were reported in your report, that it seems to me that overall the hospitals have been expanding before this new economic climate exists, and quality seems to be getting better. And so I think it's just important to recognize there are many indicators of which margins are one. All of them are imperfect.

DR. CROSSON: Thank you. Speaking to the recommendations, I support recommendation number one. I want to just mark the issue again with respect to not including a recommendation to discount by productivity

growth, because I'm going to bring that issue up in a later discussion.

With respect to recommendation two, I'd like to open the discussion that you mentioned at the beginning, which is if we go ahead with the recommended reduction in IME, where the money should go. I think, as I remember us over the last year or so talking about this, we focused on really a set of issues. One was the observation that really from the beginning, the IME payments have been about twice the empirical amount, and that that was just a political happenstance. But in fact, it has pretty much remained at that level.

We have continued to observe, although all hospitals' profitability has fallen over the time I've been on the Commission, we have continued to observe this differential between teaching hospitals and other categories of hospitals, and that there has been a sense, I think, on the Commission in a number of areas to try to use the update system when it's appropriate to address inequities that may not be fully understandable nor adjustable in other ways.

And I think also, as Peter noted, that when we made the recommendation about MS-DRGs, we recognized that we

thought at least at the time that, in general, that was going to further favorite the profitability of teaching hospitals.

So I don't think any of those arguments have particularly changed and I think I would support the recommendation, but I would argue for the alternative disposition of the funds and that they be put back into the base, essentially because that is the clearest connection to the problem statement that we started out with, which is the issue of equity.

I think pay for performance may well turn out to be useful in terms of the hospital payment system. I think the issue is still in question. I think combining these two or intermixing these two issues doesn't sort of answer the simplicity question, turning the issue into an elevator speech that's easy to understand in one sentence or paragraph. We are mixing up issues by doing that.

So my recommendation would be to support recommendation two with the money put back in the base.

MR. HACKBARTH: Thank you, Jay. And thank you for how you've framed your comments. It's very helpful to us in figuring out where we go if people can do what Jay just

modeled for us, say here's what I agree with or, as the case may be, here's what I disagree with, and give us some real clear direction, because we've got some complex issues that we will have to resolve between now and the next meeting.

DR. KANE: Actually, I want to say I do support Jay's recommendation, too, and I think I did last year, as well, so I'm happy that it's revised and, I mean, it's come back up again and I agree with it for the same reason. I think we have to realize that this is a competitive marketplace and when you give one a set of institutions an add-on that doesn't have a specific cost attached to it, you give them a competitive advantage, and it's played out in some markets rather dramatically, I think, and it's, I think, inappropriate and unfair to the hospitals that don't have a teaching program.

I was concerned -- I guess going back, I support recommendation one, but I guess I would like to see a little more on the access issue. If you go back to your slide five and you talk about some of the services that seem to be growing and then the one that isn't, I think this should be actually a little more detailed. I've heard that, for instance, the medically complex patient may have access

problems that hospitals aren't expanding necessarily the types of services that maybe the Medicare population and particularly the complex chronically ill population may need.

So one of my concerns is that in the physicians' side, when we look at physician specialty, we look at how well we're providing services in primary care versus specialty care. And yet in the hospital, we haven't done any kind of product line analysis.

I think it would benefit us to say, how well is the DRG pricing system working, not just overall, but by product line. And are there, in fact, some differential more profitable -- I know the MS-DRG went on some of that, but I think on the medically complex or the patient with dementia, I think we do need to dig in a little bit and see if there aren't pockets of concern that would lead back to the need to make more pricing adjustments in the DRG system.

So here we just have this overall, and I'm fine with the market basket, especially if I understand it correctly. But I think we need to still be concerned about the accuracy within and make ourselves aware of exactly where there might be some pricing differentials that need to

be adjusted going forward.

MR. EBELER: I had just wanted to weigh in on the IME issue, Jay, and Nancy made my point.

MR. HACKBARTH: Clearly the IME issue is one that we're going to need to talk more about, and just the way the schedule works, some of that is going to have to happen in one-on-one conversations that I have with each of you between this meeting and the January meeting.

I think the issue has been well -- or the options have been well framed here. One path is to do what we did last year, which is to reduce and put the money in a P4P pool. A second alternative would be to reduce it by the one percentage point and put the money in the base, there the goal being to try to reduce the disparity in margins. A third path would be not to reduce it at all, at least pending further discussion about training and whether we want to potentially earmark some of that money for specific objectives that we want to pursue, changing the mix of specialty or getting our new physicians trained in state-of-the-art systems, all of the sort of ideas that were laid out by our panel.

So those are the three paths that I hear from the

conversation today. We don't have much time to go into that in detail, but I would like just to give an opportunity for anybody else who hasn't spoken to this point, Peter, to offer a comment on the three IME paths that I laid out. Any thoughts there? George?

MR. GEORGE MILLER: I just have a question. Peter brought it up, about the cap issue and about the fact that the IME funds, I believe, up to a cap. What happens to those other physicians and how do we account for those dollars? I would suspect they come out of the operations of the --

MR. LISK: In terms of what the costs are, because the costs are in there in terms of -- and when we talk about what direct GME is, the costs are in on the direct GME side because they're counting them because they're legitimate Medicare costs, so it's reflected in our -- I mean, the fact that they're training over the cap is reflected in our margins.

DR. MARK MILLER: The thing to keep in mind there is, I mean, and I understand the point you were making, Peter. But if a hospital makes that decision as to whether to bring an intern or resident on above the cap, I mean,

Medicare subsidizes up to a point. It's also true that that intern or resident brings something to the hospital. There's labor, there's revenue that gets generated as a result of that, so it's not just a complete loss in bringing an additional resident in. It's just that the Medicare subsidy stops at a certain point.

MR. HACKBARTH: Remind me, I know the cap applies to the IME. Is the GME money capped, also?

MR. LISK: Yes, it also caps -- in terms of the FTE caps also apply to GME. They can be different caps, but yes, they apply to both.

MR. HACKBARTH: Other thoughts on the IME issue?

MS. BEHROOZI: Just very briefly. It struck me trying to understand this inverse correlation between the Medicare margins and private payer margins and talking about the expansion of the Medicare program is a cost to all taxpayers, well, if what is happening in that inverse correlation of margins is that costs are still growing but somebody else is paying them, not the Medicare program, that's kind of our problem, too, that the whole system is burdened with additional costs that may or may not be appropriate.

In my experience in New York, we've got a lot of hospitals that seem to have low margins in every area. But leaving that aside, your evidence shows that on average there is this inverse relationship. So it strikes me that using the IME money for quality incentives for P4P to address the kind of thing that Ron brought up, so what is it that those hospitals are doing that are managing to keep their costs low and how can we help other hospitals get there is money well spent, rather than putting it back into the base.

DR. MILSTEIN: Since this is our final round, I hope I can comment on both recommendations and say that for me, the first presentation from Evan is still on my mind, and will be evident in a moment. It influences my comments on these two recommendations, and I say that realizing it's likely very much at odds with most of the prior, but I just want to put on the record.

And that is that here we have the problem that Evan laid out in terms of the big picture. We have clear evidence that this industry is not anywhere near the so-called a price performance, the cost performance frontier, the very outer edge. It's not even close according to these

recommendations. And we are in an environment of Federal fiscal crisis.

So taking all those things into account, when I think about what we've got on the table, I come out in a different place. Where I would come out would be with respect to recommendation number one, that we should subtract for the same productivity expectation plus that's going to be on the rest of the U.S. and also take into account the burden that will be transferred to Medicare beneficiaries in next year's premiums.

And then with respect to the second, again, if you follow the logic of the connection between this and the first presentation, my inclination would be to say if we have clear evidence that we're overpaying for IME, to remove that from the hospital payment pool.

MR. HACKBARTH: There's a fourth option. I laid out three. One is put it in P4P. The second is put it in the base. The third is potentially make it contingent on certain types of performance, programmatic performance. The fourth is to give it to the Treasury. You're proposing the fourth.

DR. MILSTEIN: That's my recommendation.

MS. HANSEN: Speaking to the second recommendation in particular, I think that from previous years' discussions, I would corroborate about some of the programmatic improvements that I think some people have brought, there are ways to target this. If it is going to go ahead with taking a percentage out because of the performance, again to make sure the pricing is correct as well as the quality performance is built into that.

So the first one, I think I would support readily, but the second one, definitely some more talk about that but relative to performance on quality as well as complexity.

MR. BUTLER: The last word. Just one technical. I believe on the DME side, with respect to the caps, neither the revenue nor the costs are in part of the profit. I think you pulled both sides out. Is that right or not?

MR. LISK: No. We include GME in our overall Medicare margins. We include the revenue Medicare pays plus the costs of the -- Medicare's share of the costs of the residents.

MR. BUTLER: I'm talking about the DME, not the IME side.

MR. LISK: That's what I'm talking about, on the

GME side.

MR. BUTLER: So somebody can clarify --

MR. LISK: So the residents' salaries. So we include all the residents' salaries in benefits and Medicare revenues from those.

DR. STENSLAND: So just to be clear, if somebody has residents above the cap, those expenses are included in the margin and push that margin down.

MR. BUTLER: Well, I know they push the margin down, so we're over the cap.

DR. STENSLAND: And so when we report that Medicare margin, if we didn't include those expenses of those residents over the cap, the margin would have been higher than the one we reported.

MR. BUTLER: Okay. Then a last comment, not on the IME, just an observation because it kept coming up. Why are we increasing faster than the market basket? I would point to two quick things. One is what you would call -- and our situation would be what we call physician preference items, the cost of implants, the cost of ICD, the cost of new technology that is being demanded and often very appropriately used but pricey, and payment rates don't keep

up with it. In our budget, that would be the number one factor, and some of these things are very good, but they are expensive and they're new and they're not always -- they're obviously not captured in it.

The second would be IT. Those that have put in IT systems have incurred large new operating costs, and yes, there is some benefit. It's longer term, and actually, much of the benefit accrues to outside the hospital when you have an electronic record that's accessible and so forth, and we have voluntarily kind of used money to say, well, we've got to do this. There is not an immediate ROI. But if you looked at where our escalators are above the market basket, those two items, in particular, are ones that we've been trying to accommodate.

MR. HACKBARTH: Okay, thank you, good job.

Next we turn to updates for physician services.

MR. EBELER: This is a very exciting. Glenn has never left the room before.

MS. BOCCUTI: Don't worry, I won't take it personally.

MR. EBELER: I am now in my glory. Cristina, you may start.

MS. BOCCUTI: Okay. Thank you. This presentation is going to cover three main topics. First, I'm going to present an analysis of payment adequacy for physician services. Then Ariel is going to discuss ways to improve payment accuracy for MRI and CT services. And then Dan is going to discuss trends in ASCs.

So we have a very limited time and we're going to be going through these presentations very quickly, but if you have questions, certainly we'll have time to answer them at the end.

So as you recall, MedPAC sponsors a phone survey to obtain the most current data possible on beneficiary access to physician services. We completed this year's survey just this past October. We survey both Medicare and privately insured individuals age 50 to 64 to assess the extent to which any access problems would be unique to the Medicare population. For our access analysis, we also look at other national surveys, some of which are larger than ours, but none are more current. And this year, we increased our survey efforts substantially. We surveyed roughly 10,000 people, including surveys in five local areas that are suspected of access problems. So I just want to

take a second to recognize Hannah Neprash for her meticulous, dedicated work on that survey.

So we will first look at the ability for people to schedule doctor appointments. We continue to find that Medicare beneficiaries and privately insured people do not regularly experience delays getting an appointment. Indeed, Medicare beneficiaries are less likely to report getting delays.

On this chart, looking down the 2008 columns for each group, you can see that among those who try to schedule a routine care appointment, 76 percent of Medicare beneficiaries and 69 percent of privately insured individuals reported that they never experience delays. These are in the top yellow circles. These are statistically significant differences, so that suggest that Medicare beneficiaries are, on average, a little more satisfied with the timeliness of their routine care appointments than the privately insured population.

And then looking down, as expected for illness or injury, timely appointments were more common for both groups. Significantly greater shares of Medicare beneficiaries reported that they never experience delays.

We also analyzed these results by race and found that access problems are more likely for minorities in both the Medicare and privately insured populations. This slide shows one example, but there's more in your mailing materials and there's going to be more in the chapter.

So in this example, among the Medicare beneficiaries, minorities were significantly more likely to report always experiencing delays, and you can see that in the red. Among privately insured patients, minorities were also significantly more likely than whites to report usually experiencing delays. I put the ones in red because those are statistically significant, so I wanted to highlight that.

Although our sample shows some differences between subgroups within the minorities, such as Hispanic and African-American, we weren't able to pull them out specifically because of sample size. You lose some statistical significance, so unfortunately we collapse them into this group. But MedPAC will continue to track these issues closely.

So back to the national results, we asked respondents about their ability to find new physicians when

needed. Although not shown on this chart, it is important to realize that only 6 percent of Medicare beneficiaries and 7 percent of privately insured patients reported that they even needed to find a primary care physician in the year. So this does suggest that most are satisfied with the primary care physician that they have.

Among the small share of those looking for a new PCP, the two groups, the Medicare and the privately insured ones, were very similar, and that's the 71 and 72 percent that you see at the top circles. Those percents reflect people who said that they have no problems.

But I do want to note one concern, of course, which is in the red, which shows that 18 percent of those people looking reported big problems. However, keep in mind that given the low share of people, that 18 percent proportion comes to about 1 percent of the 3,000 Medicare beneficiaries that we sampled.

So then looking down to the specialists, as in previous years, we found that access to new specialists was generally better than access to primary care physicians, and that goes for both populations. 88 percent of Medicare beneficiaries reported no problems compared to 83 percent of

privately insured.

Other organizations have conducted surveys asking similar questions, namely the Center for Studying Health Systems Change, AARP, and CMS in the CAHPS fee-for-service survey. In the interest of time, I'm not going to go through the results that are summarized here on the screen, but I do want to emphasize that their findings are very analogous to MedPAC's.

This year, we examined beneficiary access in market areas to gain further insight into the circumstances and issues that beneficiaries face in different markets of this country. I think that the Commission has voiced some of these issues before, so we really thought that it would be good to be getting out to some of the areas. So we conducted telephone surveys and focus groups. Although we found some differences from area to area, we really did not discover a major access problems.

For our telephone surveys, we, in fact, selected five areas across the U.S. that had relatively poor access according to the CAHPS fee-for-service survey. Despite selecting them for this relatively poor access, we found their access rates to be quite similar to those found in the

national population. For example, the share of beneficiaries reporting that they never have problems scheduling routine care appointments ranged from about 76 to 83 percent in those areas.

And also, as in our national survey, we found on several questions that Medicare access appeared a little bit better compared to the privately insured cohort that we surveyed.

I also want to mention that CMS had a similar experience when they targeted special areas that they suspected of access problems. When they went back in and asked more comprehensive surveys to those areas, they also found that the results were more along the lines of the national average results.

We also conducted nine beneficiary focus groups in three markets, Richmond, Albany, and Albuquerque. Almost all beneficiaries in these focus groups said they had a regular physician, usually a primary care physician, and they could get appointments with this doctor within a day or two. We found some differences across the three markets. For example, beneficiaries in Albany generally enjoyed the best access to physician services. Problems were most

frequently cited in Albuquerque, where participants reported that privately insured people were also having problems.

In our analysis, we look at changes in the use of services per fee-for-service Medicare beneficiary. As we look at claims data cumulatively, you can see that growth has continued to increase each year, but it has slowed a little in recent years. Growth has been slower for E&M and major procedures relative to the three other categories.

We analyzed claims data also from two large insurers and compared their fees for physician services to Medicare fees. Looking at the far right bar, for 2007, Medicare rates were 80 percent of private rates. This is averaged across all services and geographic areas. You can see that this percent is just one point lower than it was last year.

So now for the second part of the adequacy framework, changes in costs for 2010. CMS's preliminary forecast for input price inflation is 2.4 percent. Within this total, CMS sorts the inputs into two major categories: Physician compensation -- that's expected to increase by 2.8 percent; and physician practice expense -- that's expected to increase by 1.9 percent.

Calculated from BLS statistics, our analysis of trends in multi-factor productivity suggest a goal of 1.3 percent. That's what we have discussed before.

Before we discuss the overall update recommendation I'm going to shift gears for a moment and reiterate the recommendation that you made in the June 2008 report. That recommendation was to increase payments for primary care services that are provided by practitioners who focus on primary care. We plan to rerun this recommendation in the update chapter, so I just want to point that out, that we're going to say it, have it put out in the chapter.

But also, before we get to the update recommendation, there are two more points I want to make. I want to mention bonuses that were put in place through MIPPA. First, the PQRI bonus, which is on all allowed charges, was increased to 2 percent. This program is voluntary, so the bonuses only apply to those practitioners who satisfactorily complete the reported requirements. In 2007, that was about 17 percent of eligible practitioners submitted data and about half of those received the bonuses.

MIPPA also created a bonus program for electronic prescribing. So for 2009 and 2010, practitioners are

eligible for an additional 2 percent on their allowed charges if they satisfy electronic prescribing requirements. And again, this is also a voluntary program.

So now onto the overall recommendation. Starting with the recommendation that you made last year, the first sentence amounted to a 1.1 percent update and the second sentence, which is great out there, recommends the confidential feedback program on resource use. As you know, MIPPA overrode the SGR and in fact enacted a 1.1 percent update for 2009, which is right in line with your recommendation.

And to the second sentence, MIPPA also required the Secretary to initiate a physician resource use program that includes confidential feedback to physicians based on Medicare claims. CMS has already begun work in this area, so we no longer need this as a part of the recommendation. However, we do plan to reiterate in the chapter the importance of designing effective education and outreach tools in this feedback effort.

So for this year's recommendation number one, it would really only be the first sentence and it would read, for the record, The Congress should update payments for

physician services in 2010 by the projected change in input prices less the Commission's expectation for productivity growth.

Since Ariel's presentation, coming next, is inclusive of physician services, we're going to discuss the implications of the recommendations after his portion.

MR. WINTER: As a you may recall from our November meeting, there were concerns about whether Medicare is paying accurately for the practice expense component of imaging services in the physician fee schedule. The cost of imaging equipment accounts for a significant portion of the practice expense payment for CT and MRI services.

On this slide, we show how CMS estimates the costs of medical equipment. The cost of the equipment per service equals its cost per minute times the number of minutes it is estimated to be used for that service. Cost per minute is based on the number of minutes it is projected to be used during its useful life, taking into account its purchase price and other factors.

In this formula, CMS assumes that all equipment is used 50 percent of the time that a practice is open for business, which equates to 25 hours per week. The main

point here is that if equipment is actually operated more frequently, the costs per service decline. This is because the fixed cost of the machine is spread across more units of service.

At the last meeting, we showed you results from a survey conducted by NORC of imaging providers in six markets which we sponsored in 2006. Today we're showing you the mean and median number of hours that MRI and CT equipment was used by these providers. As you can see from both the medians and the means, providers reported that they used their equipment for much more than the 25 hours per week that CMS assumes.

In addition to the results of the NORC survey, we also looked at data on the average number of scans per machine from a 2004 survey conducted by a market research firm called IMV. These numbers were published in a recent health affairs article by Laurence Baker. This survey's results suggest that MRI and CT machines are used more than 25 hours per week.

If CMS were to increase the equipment use rate for MRI and CT equipment to 90 percent without changing its assumption that a practice is open 50 hours per week, this

would imply the machines are used 45 hours per week. And if you go back to the last previous slide, number 15, you'll see that this is in line with the results from the NORC survey.

The Commission has supported efforts to improve payment accuracy in the fee schedule and has noted that as certain services are overvalued, this leads to undervaluing of other services, such as primary care. Even though the volume of MRI and CT services grew at a slower rate in 2007 than in previous years, this was preceded by several years of rapid growth in volume and in growth of the number of the machines on the market. Given the high level of market penetration, we should be concerned about paying accurately for these services. In addition, accurate payment rates could help manage future volume growth by discouraging low-volume providers from purchasing machines.

We recognize that improving payment accuracy will not by itself be sufficient to ensure appropriate use of these services. Other policy tools should also be considered, such as bundling and discouraging the use of imaging that is inconsistent with appropriateness guidelines.

At the last meeting, concerns were raised about access to imaging in rural areas. We want to point out that changing the equipment use assumption would only affect payments under the physician fee schedule and would not affect outpatient hospital rates. Hospitals are a source of access to MRI and CT services for emergency as well as non-emergency cases. According to the 2006 AHA Survey of Hospitals, 95 percent of rural hospitals provide CT services in their community and 79 percent of rural hospitals provided MRI services in their community. So if rural areas do not have physician offices or freestanding centers that offer MRI and CT services, most of these areas do have access to such services through a hospital.

Increasing the equipment use assumption for MRI and CT machines in a budget neutral manner would decrease practice expense RVUs for MRI and CT services and increase RVUs for all other physician services. Based on 2005 volume and the 2008 conversion factor, we estimate that payments for other physician services would increase by almost $900 million.

The higher payments would be funded by two sources. First is lower payments for CT and MRI services,

and second, additional money from the Part B Trust Fund. This is because the Deficit Reduction Act mandated that hospital outpatient rates act as a cap on fee schedule rates for imaging services. Savings from this policy are returned to the trust fund. But if the RVUs for MRI and CT codes fall below the outpatient rates, the cap would not apply and money that would have gone to the trust fund instead stays in the physician fee schedule. In other words, this would expand the pool of dollars for physician services.

This takes us to draft recommendation two: The Congress should direct the Secretary to increase the equipment use assumption used to calculate practice expense RVUs for MRI and CT machines from 50 percent to 90 percent. This change should be made in a budget neutral manner. And by budget neutrality, we mean that RVUs for MRI and CT codes would be shifted to other services.

And here now are the implications for both recommendations one and two. As you know, any increase in physician payment would increase spending relative to current law because under existing law, the SGR calls for a 21 percent decrease in payments for 2010. Regarding beneficiary provider implications, these recommendations

would increase beneficiary cost-sharing and they would maintain the current supply of and access to physicians.

Recommendation two would shift payments from MRI and CT services to other physician services.

And now we will move on to Dan's portion of the presentation.

DR. ZABINSKI: I'm going to talk about important trends that have occurred for ambulatory surgical centers in recent years, or ASCs, but first I want to just cover some important attributes about ASCs.

First, an ASC is a distinct that exists exclusively to furnish surgical services that don't require an inpatient stay. Also, ASCs that are certified to participate in the Medicare program have their own prospective payment system. Also, ASCs are a source of revenue for many physicians as most ASCs have some degree of physician ownership. Moreover, research indicates that physicians who own ASCs may be referring their more profitable patients to their own ASCs and less profitable patients to hospitals. This connection between the ASCs and physician revenue is the reason why we're considering them along with the physician update today.

Finally, 2010 is the first year since 2003 that a positive update to ASC payment rates is allowed by law.

Now, for the next few slides, we'll present some trends that reflect the financial health of ASCs. One trend we analyzed is the growth in Medicare spending for ASCs. We found strong growth in spending per fee-for-service beneficiary among ASCs, which increased by an average of 8.4 percent per year from 2002 through 2007. In addition, CMS projects continued strong spending growth for ASCs, increasing by $1 billion overall, from $2.9 billion in 2007 to $3.9 billion in 2009.

Another trend we analyzed is beneficiaries' access to ASC services. We included in this evaluation the growth in the number of Medicare certified ASCs and the growth in the service volume per fee-for-service beneficiary. As you can see in the first row of the first column on this diagram, the number of ASCs has grown rapidly in recent years, increasing by an average of 278 ASCs from 2002 through 2006, which translates to an annual growth rate of 7 percent per year. This growth has slowed slightly in recent years, but it is still robust, increasing by 257 ASCs to 2007, which translates to a growth rate of 5.5 percent.

We also found that the volume per fee-for-service beneficiary has grown at a strong rate. It has increased by an average of 10.7 percent per year from 2002 to 2006, and by 5.9 percent in 2007.

A note of interest is that this growth in the supply of ASCs and the volume per beneficiary has occurred despite ASCs having no update to their payment rates since 2003. That result is somewhat counterintuitive and ASCs don't submit cost that we could use to do a thorough evaluation of ASC financial health. Instead, the most useful information we have is quarterly reports from financial analysts on publicly traded ASC chains. These financial analyses indicate that the publicly owned ASCs have been performing pretty well financially. For example, the most recently quarterly reports show that the earnings-per-share for the publicly traded ASC chains increased by better than 10 percent from 2007 to 2008 and is projected to increase by more than 10 percent again from 2008 to 2009.

An important issue regarding ASCs is that in contrast all other health care facilities, ASCs do not submit cost data to CMS. But cost data are important for

determining the adequacy of Medicare payments and for determining the extent to which payment rates should be updated to maintain beneficiaries' access to care.

As I mentioned on the first slide of my presentation, 2010 is the first year since 2003 that a positive update to ASC payment rates is allowed by law. In response, we have developed options for an ASC update and cost reporting requirements in 2010 for the Commission's consideration. Options for an ASC update include, first, an update that is equal to the CPI-U, which is the requirement in current law and where the CPI-U is projected to be 1.9 percent in 2010. A second option is CPI-U minus the productivity adjustment of 1.3 percent. And the third option is simply a zero update.

In March 2004, the Commission recommended that the Congress should require the Secretary to collect cost data to allow for a fully informed evaluation of the adequacy of ASC payments. Here, we would like the Commission to consider an option that would make any positive update to ASC payment rates contingent upon the ASC submission of their cost data to the Secretary.

That concludes our presentation and we turn it

over for your discussion.

DR. MARK MILLER: I'm just going to append a couple of comments to the presentation on ASCs. Over the last few days, when representatives of the ASC industry learned that we were going to be looking at this again after several years with no update, there were a few phone calls in which they calmly related their points of view on that, and I thought that there were a couple of them that I would convey to you.

A couple of things. The industry is concerned that the ASCs are moving from their current payment system to a new payment system in which they're linked to -- they have their own conversion factor, but they're linked to the outpatient categories of service, and the concern there is they're making this change and we should wait until the change has been complete to see what some of the effects are. It is decidedly true that some services will go up or down as that -- specific reimbursements as that change is made.

I would also point out, though, there has also been an expansion in the number of services that can be done in ASCs, which will create more opportunities for billing

there, and some ability to do ancillaries related to the services that are being provided. But that's one concern.

A second concern that they've raised is that we should be mindful and kind of on a global sense that ambulatory surgery centers save money relative to other providers. It's decidedly true that the payment rate relative to, say, an outpatient department hospital is considerably lower. But another thing to keep in mind is that work in the past that we have done suggests that ambulatory surgery centers take less complex patients and there's also a question, which we can't answer certainly here today, of whether there's a net impact on volume if a ambulatory surgical center enters a market, takes business away from a outpatient department, does the outpatient department compensate or is there any generation of volume from the presence of the ASC?

And then the final point is that there is some concern that if this rate is cut, what ambulatory surgical centers will do is basically try and reconstitute themselves as hospitals so that they can get the higher rate, and that's certainly an issue. But, of course, that also raises a whole question of like specialty types of hospitals and

what Medicare's general policy should be there.

But at least a couple of arguments came up in these phone calls since we prepared for this presentation and I thought that people should know about them.

MR. HACKBARTH: Okay. Let me see hands for round one clarification questions. We'll start over on this side this time.

MS. BEHROOZI: Very quickly. I guess, Cristina, I will ask you. In terms of the beneficiary survey, did you collect any income level data?

MS. BOCCUTI: There is some income level data on the survey and we can look into that.

MR. GEORGE MILLER: Thank you for the report and I appreciate the information about the minority beneficiaries not being able to get access to physicians, but there's no statement made from a policy standpoint. Do you have any recommendations, how do we do with this issue? I would just suggest, and this would only be anecdotally, but the numbers may be even higher than you reported, but that wouldn't be data.

MS. BOCCUTI: That's a very good question and it's hard to answer. We've been thinking about what we could do.

I think the contribution that we make is to show that this isn't just in Medicare --

MR. GEORGE MILLER: Right. Right.

MS. BOCCUTI: It's in private, too. It's hard for Medicare to solve the problem, but I think this is a discussion that we should have. I think in this chapter, we do not offer specific policy recommendations with respect to that issue and I would leave it to the Commission to discuss that further.

MR. GEORGE MILLER: Editorializing just for a second, fundamentally, if we're talking about equality for all Americans, and I know how to frame it, but if you have one program where one beneficiary gets a benefit and another doesn't, that seems to be inequitable. Again, I agree, I don't know how to solve the problem, because you said it also was in the private sector.

My second question goes to ASC, if I can. I guess I had better come back.

MR. HACKBARTH: Go ahead.

MR. GEORGE MILLER: Okay. On the ASC presentation, and I appreciate this information, can you give me, and give me a second to get to the slide, the

impact the ASC has had on outpatient hospital services as they move from -- I think it's slide number 23. You said a percent increase volume per beneficiary. Have you been able to compare that to the hospitals and what impact that would have? Have they shifted from hospital? And do you have analysis if that has increased? If business has moved from hospital outpatient services to an ASC, has the number of procedures per beneficiary gone up or down?

DR. ZABINSKI: I'm going to tackle this first and I hope -- Ariel's been working on ASCs a lot longer than I have, so he can step in any time. But here's what I know. On average, from 2002 to 2007, the average increase in ASC services per beneficiary was 9.8 percent per year. In contrast, when you look at the same set of services, in other words, the ASC procedures that were also performed in OPDs, the average increase from 2002 to 2007 was 1.3 percent per year. So the much slower growth rate in the OPDs. Whether that indicates that there's been some transfer or migration from OPDs to ASCs, I guess it might indicate that but I don't have anything to say that's certainly true.

Anything to add, Ariel?

DR. MARK MILLER: The overall volume in the OPD

that we just went through -- and you've made the distinction for kind of shared procedures, but the overall volume we just went through in the hospital presentation, it's growing overall. It's growing very aggressively.

DR. ZABINSKI: Right. That's true.

MR. HACKBARTH: It doesn't necessarily follow that there's a substitution. There could be some substitution of A to C for hospital outpatient department, but there also could be some induced growth, much as we found some evidence of in the case of physician-owned specialty hospitals.

MS. HANSEN: Clarification for access to primary care on this. Perhaps there are only like 6 percent of people who are going to be looking for that. Has it been separated out to look at people who turn Medicare-eligible, who already have coverage, you know, perhaps they're covered because they're related to some program, whether a retirement program or all? I'm probably more curious about the access for people who were uncovered and suddenly because of Medicare they now have access, and that seems to be always a more complex population. So is that separated out so that we look at the access of coverage for that newly covered group?

MS. BOCCUTI: No, it's not separated there, and that's a research question that people have looked into and I can refer you to some articles on that. It's been called sort of like the shelf, I think effect.

Whether it's looked at specifically about how that affects their primary care services, I can't say off the top of my head. But I'll refer you after this to a couple articles that I know about that.

But through our survey, we are not able to determine of the Medicare beneficiaries what their previous insurance status was. And then it would only be getting to that small share among the whole Medicare population that just became Medicare eligible.

I will say that people who newly come to Medicare can be switching insurance, essentially, and may have to find a new doctor for whatever reason. So they may be overrepresented in the 6 percent. But in fact, because most physicians are taking Medicare, that's not as much of a problem as if they go the opposite direction, switching employers or where you have to switch -- if you're switching a different insurance type. Whether your physician takes that insurance becomes a question.

MS. HANSEN: Right. And this then ties then to one of the recommendations here relative to access to primary care and the fact that that still is potentially a problem as the numbers grow.

And then related to that same area with the CAHPS study that shows that access -- there are two questions basically there, and it seems like because, I believe, the beneficiary number there that's done under the CAHPS is about 100,000 to 120,000, would that be a place potentially for a question on access to primary care? Because I think we all have heard anecdotally that this is the case, that people are beginning to feel the difficulty. And again, this is anecdotally. But whether or not that can be built in possibly or as a recommendation to CMS to include that, since that's such a routine question on the routine surveys.

MS. BOCCUTI: I see what you're saying. Right. I don't think they have a specific primary care physician access question. It's more about medical care and getting appointments and access to a specialist.

But you are suggesting that we turn to this very large survey and suggest that they really hone in on the primary care aspect. We can talk about that.

MS. HANSEN: And I just want to say thank you again for the coverage on the issues of access, both here and in the ED part, because I know we didn't discuss it here, but it's in your chapter, and that's interesting also in terms of the patterns of utilization by Medicare beneficiaries.

MS. BOCCUTI: Yes. I will mention Nancy Ray worked on that and we're hoping to be able to increase that section maybe in the future reports. But we thought we'd start investigating it in this venue.

MR. HACKBARTH: We're still on round one clarifying questions.

MR. BERTKO: This is a clarifying question on the draft recommendation on physician spending increase. When you recommend this, is it a one-year bonus kind of arrangement that you're suggesting or is it update to the baseline?

Then the second part of that would be is it in the January meeting that you give us the spending ranges for how much this would have an impact?

MS. BOCCUTI: The easy question first is the latter part. Yes. The buckets that you're referring to

come in at the next part of the meeting.

But the answer to the first part of your question really gets into how this is scored and whether it's in the baseline or it's a bonus, so then the SGR doesn't -- I would say that we compare it to current law, so that's why we get the increase. So no matter how you did it, it would be an increase.

But it's a generally been the position that the Commission hasn't gotten so involved with the scoring and how this is going to be allocated, really more the bottom line of what's going to happen with that sector and the update for that coming year. But I'd turn to you if you want to --

MR. HACKBARTH: I think that's right, Cristina. As you well know, John, there are big differences in scoring effects based on whether you define this as a bonus that's got to be paid back in essence the next year through a bigger reduction or whether you just say it's an increase. But that's really beyond our purview, I think. The message that we want to send is for the fiscal year in question that we think there ought to be an increase of X-percent.

MR. BERTKO: I completely agree with what you say,

but it seems useful for us to comment on how much of a deferred budget item, or whatever you would want to call it, might be emerging when you do the bonus end of it, because we keep pushing this off into the future, and while again it's not our purview to do it, just noting it might be useful.

MR. HACKBARTH: The cuts implied either way in the future are so beyond the scale of anything that's realistic, it really has become a game in how you play the budget scoring system as opposed to a substantive policy debate.

DR. BORMAN: Could one of you or any other staff member remind the me the year in which the screening colonoscopy benefit became available as a covered service?

MR. WINTER: I think it was BBA 97, but we'll check on that and get back to you.

DR. BORMAN: Okay. For obvious reasons, I just would comment that we need to be a little bit careful about the connotation of the term surgical. For folks like me, it implies different things that it implies in this designation, and this may include a number of interventional activities that are not classic open surgery.

DR. CASTELLANOS: Thank you. I have three

questions, sort of like what Nancy did the last time. The first one I have is about indicators for payment for physicians. Really, we're just looking at access and we're comparing with other private sectors and I think we're somewhat limited in what we're looking at. I would like to personally work with the staff, perhaps, and see if we can look at some other indicators.

One of the indicators we're seeing now is access to capital and the cost. As you mentioned, yes, E-prescription is going to be a bonus, but we have to buy the equipment, and if we don't do it by 2014 we get penalized. So it is a cost to the practice, especially a one- or two-man practice, and especially with EMR.

My second question is I'm somewhat bothered by the tone of the subject of sustainability in Part B. My question is that the physicians' part of Part B is only 40 percent, and shouldn't we look at the other 60 percent of Part B, because that certainly drives that premiums and sustainability.

And my third question is on ASCs. I'm just a little curious to know why this isn't a separate chapter. The reason is so we can expand the discussion to include

more information on the differences between the hospital and the ASC cost, satisfaction, efficiency, convenience, quality, and savings to the Medicare market.

MS. BOCCUTI: I'm just going to mention a couple of things. There are other analyses that we have that we just couldn't present today but were in the chapter that we do with physicians, like, for instance, participation rates. Physician signing up for participation, those are in the 90s and even went up slightly this year. The percentage of claims that are taken on assignment, that is accepted Medicare's payment in full rather than allowing a little bump up for balance billing, those are in the mid-90 percent. There are other reasons why that's beneficial to physicians in addition to payment. But there are other factors that we examined that we put in.

And with respect to access to capital, it's challenging to do that for physician offices. So if you have ideas on that, you know, we don't have cost reports for physicians. It's hard to get a sense of what other factors we could be examining that would give us information on payment adequacy.

MR. HACKBARTH: As for the other part of Part B,

of course, there are other expenditures in Part B, a big one being Part B drugs, although we don't approach that as an update issue because the law isn't written that way. At times in the past, we've spent a lot of time talking about the payment methods for Part B drugs and how the level of payment in the rate of growth might be slowed. In fact, significant policy changes have been made in Part B drug payment in recent years.

MR. BUTLER: Two points, or questions, I should say. The first relates to a perception. You don't talk much at all about payer mix for ASCs and there's a perception and I know that there's data somewhere out there that is related to this, that often they do not take Medicaid, reluctantly take Medicare, and obviously enjoy private payers much more. So one question is, remind me what data you might have with respect to the range of patients and is it reflective or not of the overall population.

Second, on your recommendation on making the updates contingent on supplying cost information, have you practically thought about how that would be done? And could it be done in a way that kind of makes sense, as good as the

idea might be?

DR. MARK MILLER: The way it's happened in the past, we have done some discussion about this. This is not -- we don't have this all figured out. But there's been a couple of efforts in the past in which surveys have been done with ambulatory surgery centers. That could be a starting point where you could begin to get that out and try and get information back. They are probably not the level of detail where you'd like to be in terms of breaking things down by the types of cost, but we feel that there's at least a something there -- and I'm kind of looking at Ariel to make sure I'm not completely talking about the wrong payment area -- that something there that you could at least start with to get an instrument out and the information starting to come back. But probably not the perfect thing.

DR. STUART: I have a clarifying question on slide 15. When we get to the discussion of recommendation two, which is expressed in terms of a capacity utilization rate, and my question is really what do we assume capacity is here in terms of the number of operating hours? We have a mean number of hours used per week for CT and MRI of 48 and 65. Did the NORC survey ask the question of how many hours those

units were open?

MR. WINTER: Yes they did. What we reported to you last time was the percentage based on, so the number down there for mean MRI providers would be the numerator. The denominator was -- I forget the exact number, but the resulting percentage was 90 percent, so maybe it was 70 or 75 with the hours they were open for business.

With CMS, there are two sort of parts to their formula that we can look at. One is the standard hours a practice is open for business, which they assume to be 50 based on AMA and MGMA data. The other factor is what percentage of the time is the equipment used that the practice is open for business, and so they assume 50.

But the number that matters is the hours the equipment is used per week and per year. So what they get is 25, half of 50 hours per week. So we're trying to focus on rather than the use percentage, what are the hours, or what is the reasonable estimate of the hours per week the equipment is used. That's why we're presenting hours at this presentation, because last time we did the percentage.

DR. STUART: I agree, I think that's what we ought to be doing, but the recommendation is in terms of percent

and so there's kind of a disconnect between the facts here and the recommendation.

MR. WINTER: An alternative would be increase the estimate of number of hours per week used to 45, and that would be the same mathematically as going to 90 percent off a 50-hour base. We could think about changing that.

DR. KANE: Two questions. One is, since it is apparently the practice expense way of doing equipment is just to assume this 50 percent of a 50-hour week, why did we just pick two large pieces of equipment and not all to apply this recommendation to?

MR. WINTER: We talked about last time expanding it to things like nuclear medicine cameras or PET machines. The reason we're focusing on MRI and CT here is because we have done a survey on those providers and we're trying to focus more on an empirical basis for an estimate right now than an efficiency expectation like we talked about last time. So these are the data that we have done, that we have been able to acquire. But on the AMA practice cost survey that is in the field right now, it is asking about other pieces of expensive equipment, not just these two. And so there may be information that comes out of that survey that

would lead us to consider a similar recommendation for other kinds of equipment.

DR. KANE: I think we would want to be a little more broad than just picking on two -- anyway, the other question is in trying to understand the access issues, have we checked at all with the differential that MA plans pay, say, primary care docs in the market and gotten a sense of whether there is one, and if so, what that has meant in terms of impact on availability of doctors in those markets?

MS. BOCCUTI: You know, Carlos Zarabozo has been thinking about this and has some anecdotal information from something that I read, but I'm not aware that we have a systematic analysis on fees paid in this regard. As I understand it, with the MA payments, it's hard to discern how much they're paying the physicians from that sort of box of payments. So that makes it challenging, but we have reports.

We tried a little bit in the access survey to determine MA and fee-for-service, and it is very hard to survey beneficiaries over the phone and have them know whether they're in a MA plan, but it is just to, well, if I knew an area had a certain percentage, is access different

when you get to an area with a high percent versus a low percent and could we start thinking about maybe there's differences in payment. It is very challenging to find out that information, but it's a good question.

Is there anything you want to add Carlos? Okay.

MR. HACKBARTH: Any other initial questions?

We are at 12:05 and so we're five minutes behind right now. What I would like to do is allot about 10 minutes more for this conversation. What I'd like to get out of the next round is a better sense of where people are on the three recommendations that are in this package. One is for the physician update. Two is on the practice expense RVUs for imaging. And third is on ASCs, and that actually has two components with the update and the idea of requiring cost reporting information.

And so what I'd like to do is have this round of comments be focused on reservations that people have. If you have reservations about one or more of those draft recommendations, I would like to hear them and understand them.

DR. CHERNEW: I do, and it's much easier when you give us two or three recommendations and we can choose

which, but my concern throughout is how this affects sort of the access to primary care, and I have been skeptical in this discussion that say changing or increasing the payment rates would improve access one way or another. I think there are other barriers, like capacity, and I like to look at other measures like hours worked.

So my concern that I had about the imaging one was I was curious to know, how much of the imaging is done -- in the office-based imaging is done in primary care versus specialists? If I knew the answer to that, it might influence how I felt about that particular issue.

So I guess just to stay on the point that Glenn asked, I'm skeptical of asking the ASC providers for costs at this point because I think there are other indicators of the health of the ASC industry that would transcend whatever the cost numbers would show me, I guess is my general view. But I do think --

DR. REISCHAUER: Such as?

DR. CHERNEW: They are growing at --

MR. HACKBARTH: The influx of capital into the business.

DR. CHERNEW: Yes. People are getting huge

amounts of stuff. So making them go through an administrative exercise to fill out an elaborate set of cost reports to show how well or not they are doing doesn't strike me as where I would -- it is costly to do and I don't think the answer, at least right now I would pretty much be surprised -- if it showed -- a mentor of mine once said, I don't think you're going to find -- if you find what I think you're going to find, I knew it anyway, and if you don't find that, I'm not going to believe it, and that's how I feel about the cost --

MR. HACKBARTH: Well, let me just ask you this. The influx of capital into the field is a directional signal that the payment rates may be relatively generous. It doesn't help you much in terms of magnitude. How would you think about the magnitude issue absent cost information?

DR. CHERNEW: Well, I guess the reason I said there were the three ASC recommendations you had there, the lower one was a zero update one and I would be comfortable with that, and if you thought we needed to go lower than that and wanted cost information to find that, I'm not sure that would be worth it, but I don't think that's what you're alluding to.

DR. REISCHAUER: I don't want to take a second position to anybody on the, do red flashing lights go off in my head when I see very rapid increases in some service, and particularly when it's provided by those in the for-profit sector, but as Nancy and others have mentioned, many of these services are provided in different venues and we really don't know the answer to whether this is shifts out of outpatient hospital or out of doctors' facilities. We don't know about the relative safety in some of these areas.

And so I think we do need to begin collecting this kind of information, the cost information, especially because we want to ask ourselves, you know, we know it's going to take three or four years to get all of this stuff going and are we going to need it three or four years from now, and my answer would be yes.

MR. WINTER: On imaging payments, regarding Mike's question about breakdown by specialty. So in terms of imaging generally, and it's particularly true for advanced imaging, most of the payments are going to freestanding imaging centers, radiologists, and other specialties. A minority goes to primary care. We can get you more detailed in time for the next meeting.

DR. CROSSON: I will speak to recommendation number one, and I have a concern that I've raised I think in the past, and it has to do with including productivity growth expectation or reducing the update by the expectation for productivity growth for physicians.

Understanding that there is a gigantic subtext or supertext to this entire discussion which is political and has to do with SGR reform and other things that may take place, I still have two issues. Number one is the optics of it, if you well, particularly again in comparison to the recommendation that we've made for hospitals. I think if we are going to make this decision between physicians and hospitals, we ought to at least have an explicit discussion of why we think it's different.

The second concern I have, and I've expressed this before, is trying to understand what productivity growth actually means when applied to physician practices. I have a harder time -- and this may be my failing -- I have a harder time understanding that than I do, for example, institutions. And my concern is, if we go to page six for a moment, I think the thing that struck me here is the increase in the "big problem" in access in primary care

compared with what appears to be -- and these are small numbers I would assume -- a decrease in the big problem in access to specialty care over the last few years.

Recognizing that we're only dealing with the subset of individuals here who are looking for a new physician, it strikes me that this is a lagging indicator, if anything, correct? And that jibes with what I see and hear in actual life, which is that the expectation of the crisis here in primary care access is gigantic. My concern has to do with whether or not we really understand what we're talking about when we're talking about increases in productivity in the physician practices and whether there is, in fact, a differential opportunity for productivity increases depending upon what specialty you're talking about.

And again, maybe this is that I don't understand this very well, but it would just seem to me that productivity increases are harder for an individual who's working with nothing but his or her hands and mind than it is for someone who has a much more complex economic model that they are operating in with multiple services and diagnostic testing and things of that nature.

And so the question is are we, in fact, exacerbating the problem here by using this particular slice, which is the productivity growth? And is it possible before we make this recommendation final to understand a little bit more about what we mean by productivity growth as it applies to physician practice?

MR. HACKBARTH: You've raised some important and complex issues that we're not going to be able to resolve today. Having said that, I think based on past discussions we've had, I think it's fair to say that the consensus is that the productivity opportunities are not uniform across physician practices, and in fact, some specialties seem to have greater ability to increase their volume for a variety of different reasons than primary care.

The policy question is where do you take that into account? Do you increase the size of the overall physician payment pool based on the ability of the lowest group, primary care physicians, to increase their productivity? Or do you say, what we ought to do is increase the overall pool by a modest amount, but increase the relative payment for primary care versus the high volume specialties?

I would be inclined to the latter, and in fact

we've made a recommendation to do just that to the primary care modifier. If you increase it across the board for everybody, then the high volume people who are generating all this stuff and making tons of money on Medicare are going to get the same increase. So that's the policy question that I hear in your statement.

DR. MILSTEIN: With regard to recommendation one, I support it as stated. And addressing Jay's point, I believe that same logic should apply to hospitals, as I mentioned earlier for the reasons I mentioned earlier.

With respect to the overpayment due to the underestimate on imaging hours used, but again for the same logic as in the hospital discussion, I think it should be returned to the Treasury and obviously benefit the beneficiaries in the form of premium reduction.

And then I support the recommendation on ASCs that is linking any update to provision of cost information, although I believe we should increase the contingency so it is cost and quality information.

MR. EBELER: Again, supportive of one and two, I think Nancy poses an interesting challenge in two about whether we can make this specific recommendation but come up

with some way of directing the Secretary to continue to do this in other services. I thought that was a good point. And three, I'm also supportive of the cost information. I think quality is a good addition.

I would note is not necessarily to help us with this particular update recommendation. Obviously, it won't come in time for that. But I think over time, the Commission has generally wanted data from those to whom we mail money and it does provide helpful information to the Congress and it keeps both the provider group as well as the budget process honest in some ways, which I'd have to look at this as but one component, not the only one, of a financing problem.

DR. BORMAN: Briefly, with regards to number one, I, too, have some concerns about the productivity adjustment propriety, perhaps for some different reasons from Jay, but just leave it at that in the interest of time.

Secondly, with regards to number two and the imaging recommendation, I would agree about the extension to other services, but I think I'm comfortable with this as written.

And then thirdly, with regards to the ASC updates,

I think that the data that has been presented thus far certainly make one lean to the expectation of a zero update. I would maybe ask whether it's possible to have a negative update, given the data. But since in fairness we consider that in other sectors, and so I think we have to raise it in fairness in this one.

And then I would like to point out, however, because I have -- and maybe it's some sensitivity on my part, I do sense a little bit perhaps more negativity about ASCs than I think may be entirely justified in that there are reasons for having an ASC that are not just a way for physicians to generate alternative income. If I'm a surgeon and I do a high volume of procedures that lend themselves to ambulatory surgery, it is hugely more efficient for me in terms of controlling my time and in having staff responsive to my needs to be part of an ASC, generally speaking, because they are geared to be very short turnover, very efficient, very user-friendly. The demands upon operating endoscopy facilities in large hospitals are numerous and it is virtually impossible for many of them to offer that same level of scheduling, predictability, and service to users. So please just know that there are some things behind

utilizing an ASC for a fair chunk of your work that relate to patient convenience, predictability of scheduling, and so forth, and I think that's an important thing.

Relative to the cost reporting, again, I respect Mike's point about needless imposition of work on people. On the other hand, we do require information, as Jack has pointed out, about people that we mail money to. And so in fairness, there should be some expectation of data from which to go forward, since this is an opening year of a process.

MR. HACKBARTH: I would second what you said about the reasons for physicians wanting to use ASCs. I ran a large group practice. The salaried physicians -- this was not a financial matter whatsoever for them. But they really welcomed the opportunity to do at least some of their ambulatory cases in a freestanding facility as opposed to in a hospital outpatient department.

DR. CASTELLANOS: As far as the updates go, I have some very great concerns on this. As you know, we're trying to get a primary care bonus and that's coming away from the specialist. That's going to be 0.5 off that. So really, if you look at what you are potentially recommending, you're

talking about a 1.1 percent update, but for non-primary care you're going to have to take 0.5 off that again. So you're really getting down to 0.6 percent update except for primary care. I really have a significant concern, because it doesn't even come close to our increase in our costs.

I have the same concerns Jay has about productivity. Again, my concern on the first question was basically the indicator we're using is access to care. And again, I think there are cracks in the wall. I think there's a crack in the wall with primary care. In the material that was sent to the Commissioners, on page 16, the Center for Studying Health System Changes, if you look at that, when access to care -- you've got to look at trends, and there's a trend here on every patient, whether it's Medicare or not Medicare, for access to care. There is no question that the minorities have had some problems with access to care, even though they're supposed to have equal access under law.

So I have a lot of concerns. I think we may be able to do something by not taking a full productivity or no productivity.

With respect to the practice expense, there's no

question, we need to get reimbursement closer to costs. There's no question we need to do that. My concern on this is two things. One, CMS came to the -- I made this point last time. CMS came to the AMA about two years ago and said, we need a whole study on practice expense. The AMA went out to every specialty society at a tremendous cost both to CMS and to the AMA and to all specialties. I happened to fill out that, and it took me three hours, and I'm supposed to know a little bit more of what I'm doing than a lot of the doctors.

The message here is we have a survey that will be finished this year, and I can understand trying to get this, but the NORC survey is only on six urban centers. It's not a rural or countrywide survey. I'm not sure what the rush is, but I guess that's one of the issues.

The other issue I really have on this is that we are focusing in on physician overutilization and increased costs. I think all of you look at this imaging study that came out on Health Affairs, and they showed that in that study that there was very little difference between physician ownership and the HMO physician usage. In other words, maybe there are other issues that we need to start

looking at. Maybe we need to start looking at practice patterns. We need to look at standards of care besides just cost.

And the third issue on ASCs, I don't think we had a long enough discussion. I would be very hesitant to be able to make any decision on the few minutes of discussion we had today.

DR. KANE: On recommendation two, I think we should assume that it is possible to do a 90 percent across most pieces of equipment and if not -- I mean, I'm not so sure we had to wait to see what actual is for every piece of equipment out there, and it's probably impossible anyway. I'm not sure why we have to be sure that every single piece of equipment is used at 90 percent. I think we should assume it can be and that maybe you shouldn't buy it if you can't justify it at that level.

So rather than waiting for surveys and data, we have shown that it can be done in 90 percent and I don't see why we shouldn't just say that should be the standard rather than 50. I don't know where the 50 came from, but I'm sure it was a political compromise and maybe we should just up the compromise to 90 percent. So I'm happy to extend it now

at 90 without waiting for a whole lot more data, because I think we should be more normative than descriptive in these kinds of standards.

And then for the ambulatory surgery, I don't think we should make the submission of cost contingent on anything. Either we want it or we don't, and I think we do want it for longer term purposes. I think we have a lot of trouble already understanding the cost of physician practice. This gives us a window into some practices that actually have some shared overhead so they can actually create a cost reporting system that would be relatively more credible than the individual doctor's office. I think we need more information about what practice expenses really are in these different types of settings.

So I don't see why as to be contingent on a positive update. I think we should be -- as one who try to create a cost data, a cost reporting data set for physician practices, that was a nightmare. I think it's great to take an organization that actually has some administrative talent there to try to get the cost data out of them and see how it informs you not only on a ambulatory surgical centers but on other costs that are changing for physician practice. So I

don't see why it should be linked to any update. I would just go ahead and say we should have it.

The update itself, I would say zero for the ASC, given what's going on in the marketplace. Just as Mike says, I don't need to know the cost data to say that, but I think the cost data can be useful for other things.

MR. HACKBARTH: I have Peter and Bob and then we need to go to the public comment period.

MR. BUTLER: Okay. With recommendation one, I can support it. I think that I am highly sensitive to the productivity issues. I think what's weighing on me is that I do see volume increases and volumes incentivize still under the system that is still a little bit making up for the lack of a full update. So I'm kind of thinking, how do you factor that in in some way? And I think in the bigger context, I think that the recommendation is okay.

I do think with respect to George's and others' points on access, not just minorities but poor and overall, we just need to beef up the language in the chapter a little bit more and say we're going to redouble our efforts to kind of monitor that and try to understand it.

With respect to two, I'm okay with it as it is.

With respect to three, given the data I have today, I would recommend a zero with not going after the cost information because I do suspect it would be somewhat of a burden. But I base that on the fact that we have, as Mark pointed out, added in a lot of new procedures that can now be done in ambulatory surgery centers. I would just as soon see what happens in utilization with respect to that.

I'm open on, though, this third recommendation if they have some data on the payer mix issue that would, you know, because I expect we're paying too low for Medicare. If somebody was doing all Medicare, they're probably losing their shirts. Yet in the absence of some of that data, I'm inclined to support zero.

DR. REISCHAUER: With respect to recommendation one and the productivity adjustment, I have sympathy for what Jay says, but on the other side, I think some of this, of his argument is related to the inefficient scale of much of doctor services in onesies and twosies and threesies, and I want to keep pressure on that sector to organize itself in more efficient ways. And so I will go along with that recommendation.

With respect to the second one, I'm basically

where Nancy is in the sense that with respect to MRIs and other advanced scanners for which we have data, I think we should not be looking at what current behavior is, what the average of the median is, but looking at the top 10 percentile in terms of efficiency and saying what is feasible, what is possible here, because what we're reflecting is a supply of these machines that has responded to probably an overpayment. And then we look at it and say, well, we want to justify it. It's more than justified at this point. But I would think particularly in urban areas where there are lots of competing ones, sort of the last thing we want to do is say that's the right amount to have. There's a different probably problem probably in rural areas and so you want to make sure there is access there.

With respect to the third recommendation, I guess what I'd like to see is an analysis of the volume increase procedure by procedure for all of Medicare and then that in outpatient facilities, that in ASCs, that in doctors' offices where we can see sort of what's happening. How much of this is a shift one way or another? And until you sort of -- from one venue to another. And until we know that, I guess I would stick with zero. And I'm for conditionality.

MR. HACKBARTH: What about the other part of what Nancy said on imaging? She said two things. One is go to a normative standard. And the second thing was don't just do it with MRI and CT. Do it for all of the --

DR. REISCHAUER: I think it's a whole lot easier task if you go to the normative by it because you don't have to do this full sample. You can just look around at these other things and say, who's the most efficient in town? Let's see what their practice is --

MR. HACKBARTH: But you would extend it to --

DR. REISCHAUER: -- and then we will apply 10 percent less than that to everybody.

MR. HACKBARTH: Okay. Thank you all. Good job in the presentations.

We will now have a brief public comment period. The ground rules are these. Number one, please identify yourself and your organization and limit your comments to no more than two minutes. When this red light comes back on, that means your two minutes are up and please wind up your comments.

MR. FENIGER: Randy Feniger for the American Society for Gastrointestinal Endoscopy. I would like to

direct my comments on the ASC discussion. I would concur with remarks that were made that it's too bad this was not a separate discussion with greater, because essentially what I'm hearing is the basis for the decisions and recommendations, rather, is the same thing I heard in 2002: well, there's growth, ergo, the Medicare rates must be right. I think a great deal has changed, speaking only for GI. Most of those centers are single-specialty facilities, providing only endoscopy. They're in -- halfway through the change to a new payment system, as you know. They are already experiencing the negative update as our rates have dropped both years, and will continue to drop as programmed through the life of the transition.

We are seeing episodically -- it's not yet consistent -- multi-specialty centers reducing the amount of endoscopy that they will accept, particularly Medicare. It's already been stated there is very little capacity in hospitals to take those cases. Physicians are struggling in some communities to find another ASC, another site, in which to provide those services. That really just translates to waiting times for things like cancer screening or other diagnostic and therapeutic procedures, which does not

benefit the beneficiary.

These centers are not easily able to change the mix of their services, either because of licensing requirements or CON in the state, which limit what they can provide so to say, well, they should just invite their orthopedic friends to come over and work with them is just not a realistic option for most of these facilities.

They have, has been said, no update. The last of it was 2003. There were no updates before that. We are all faced in those facilities, as is every other health provider, with a current economic situation. I would argue for a full update. The CPI does not measure the full medical inflation, as you know, but it is certainly better than the direction that we are going on right now.

I would encourage you not to link cost reporting to anything. There is no mechanism in these facilities to provide the kinds of cost reports that you are typically seeing in hospitals. That would have to be constructed. That would be a cost both to Medicare and to these facilities that doesn't exist. And I would just say about surveys, every single survey that has been tried on ASCs has failed to produce information that is relevant to their

cost. So I'm not sure that is a very good option. Thank you.

MR. HACKBARTH: I realize that two minutes doesn't seem like a lot and it's frustrating, but we only have a certain amount of time to get our work done, and so I really need people to limit their comments to two minutes.

I would remind folks, many of you know this and do it, this isn't the only avenue to communicate with the Commission. The staff go to extraordinary lengths to reach out and talk to people who have knowledge and interest in these issues. We all read our mail. We get a lot of it and we read it. So don't think this is the only opportunity.

MR. MAY: Thank you, Mr. Chairman. Don May with the American Hospital Association, and just a couple of comments today.

I think there is one thing very different this year than what we've seen in other years and that is the economy, and the huge change in our economy and in our country, and in the world, I guess, with what is going on now, and I don't think that that can be left out of your discussion. I think it clearly indicates a need for a full update when you combine that with the other factors related

to hospitals.

When you look at hospitals and you look at the margins for hospitals, what we've seen over the last few years is this downward trend in Medicare payment performance. This alone would suggest that Medicare payments are inadequate. The Commission has done a lot of work at trying to find efficient providers and how do you define that? Last year, when you looked at the consistently low-cost providers, they still have a negative Medicare margin.

This year, when you presented this new information about highly efficient and high-quality hospitals, again, we see they're barely breaking even. I think what that really begins to tell you in a pretty clear way, is that hospital payments are inadequate and a full update recommendation is appropriate.

The last point is in regard to indirect medical education. The conversation today was a really good one and I think it talked a lot about the concerns about accountability, where IME dollars are going and what are we doing with this and what type of medical education are we getting? And those are good discussions and sounds like you have set a plan to discuss this even further. I think it

probably makes sense to have this discussion about what the total IME pool should be as part of that broader discussion about what accountability do we want to have and what kind of direction do we have for medical education, and would encourage you to move the debate about total IME funding into those broader IME discussions.

Thank you.

MS. FISHER: Karen Fisher from the Association of American Medical Colleges. We represent all of the allopathic medical schools in the country, as well as the large, major teaching hospitals.

Let me support the comments that the AHA made regarding both the financial condition and the IME adjustment. I will keep my comments brief.

First, on the DSH issue, I think MedPAC has recognized, other policymakers have recognized in the past, that the role of the Medicare DSH adjustment has been to help offset the cost associated with uninsured individuals to ensure access to those institutions for Medicare beneficiaries. The problem is, in the margin calculations, the DSH payments are in the calculation, but the costs for the people that the payments are intended for, the uninsured

patients, are not in the calculation, so you have a deliberate overpayment. That amount of money is over $5 billion. It affects the margins for all hospitals, but it acutely and significantly affects the margins for major teaching hospitals.

We obviously think a cut to IME right now is ill advised given the economy, given the fact that major teaching hospitals are already absorbing a $385 million cut to capital IME payments, as well as the large urban add-on.

I'd like to point out that, while reducing IME payments might narrow the gap with other Medicare margins for other hospitals, for Medicare, it would exacerbate the gap in total margins between major teaching hospitals and other hospitals. And that's the ultimate financial measure for the ability for hospitals to provide high-quality patient care.

Finally, in terms of the accountability issue, I agree with Dawn. I think that needs more discussion; it was a good start today. We're not opposed to accountability, it's trying to figure out how to do that, but I do need to point out that the IME payments are used to offset costs in hospitals, and those costs are mission-related that benefit

patient care and other mission-related activities that are done in those institutions that benefit the community and the society as a whole. So, it's important to remember they are being used for something. They're being used to offset cost for activities that occur in those institutions that we believe benefit the community and society at large. Thank you.

MS. LOWE: Marian Lowe, on behalf of the ASC Association.

We appreciate the discussion today, and also Mark's comments, following the discussion of payments in ambulatory surgery centers. We are very concerned about eliminating an update recommendation for 2010 before we have any data of our experience under a substantially revised payment system in 2008. That is one of our many concerns.

Also we wanted to welcome a more robust discussion of surgery center issues. This Commission has not had a discussion of ASC payment issues since 2003, and we would like to see some of those issues about how the new payment system was set up and the incentives encouraged under this new system discussed with this group before moving into a more robust discussion of updating payments in the future.

I want to hit a couple of issues that were brought up in the comments. One, on payer mix, many state Medicaid programs do not allow payment in ambulatory surgery centers. So there are some places where the aggregate number won't reflect what is happening locally, so we would encourage a more local look at how payer mix is distributed.

Also, on the side of revenue potential for surgery centers, under the old payment system there were nine payment groups and all of the ancillaries that were mentioned were covered under that group payment rate and now they are being billed separately, consistent without the outpatient PPS system is set up. And again, until we have claims data to illustrate how the industry has responded, we don't want to see that get thrown in as a discussion of inappropriate revenue potential.

Also, many of the new services that come online in the ASC under this new payment system are kept at the physician office rate. So there's already incentives to not bring those services into the ASC and we've heard from our members that there's not significant interest in bringing those services into the facility. We will certainly be providing more data between now and the January meeting and

welcome that discussion, but also just to echo the comments of Randy about our concern of the decline in payment rates for many of the services on which the ASC industry is built.

Thank you.

MR. ROMANSKY: Thank you. My name is Mike Romansky. I'm counsel to the Outpatient Ophthalmic Surgery Society. We represent about 20 percent of the nation's ASCs that are primarily ophthalmology oriented. What's a little bit unique about these facilities is that they don't accept a lot of Medicare patients, because Medicare patients generally don't require cataract surgery, and these are facilities that, like the urology and the endoscopy facilities, can't just readily change their specialty mix.

We agree completely with Randy and Marian's comments. We're concerned about precipitous action on this point when we're really midway through the transition period.

I'd like to take specific issue, though, with the staff suggestion that ASC gross statistics are really a fair proxy for how profitable ASCs are. There are a lot of reasons why the ASC industry has grown. I think if you were to look state-by-state, you would find that in those states

where CON laws are relaxed, you see a great deal of growth in ASCs. You will find that technological advancements make a difference. Surgeons, as one of the Commissioners suggested, like the productivity in ASCs. The patient's demand the services. We think that that accounts much more than the Wall Street indicators or the growth certificates for the significant growth in the industry. We look forward to working with the Commission.

Thank you.

MS. McILRATH: Sharon McIlrath with the AMA. I just wanted to start by pointing out that the gap today between -- or in 2009, physicians will be being paid 1.6 percent higher than they were in 2001. By Medicare's calculation, costs during that period have gone up 22 percent.

Then, other data would indicate that the Medicare cost number is inadequate anyway. MGMA cost data usually runs about double what the Medicare data does. One of the reasons for this is because the MEI is measuring a fixed basket of services that goes back to 1973, so that a lot of the things that are in physicians offices today, the number of staff that they have today, is not reflected in what is

being measured. I think some data that you guys talked about in October said that just in the last six or seven years -- maybe it was a little longer than that -- there's been a 27 percent increase in employment in physician offices. That is not really being reflected in the MEI. One of the reasons I wanted to bring that up is because if you're looking at increases in productivity, yes, there are a lot of specialties that can have more increases and oftentimes it's because they have added staff or because they have added equipment. And to the extent that that was never in the market basket, it's not being picked up. So even for those services where productivity has increased the pool as a whole -- I mean, the physicians that are doing those and those services are getting a higher practice expense, but the pool as a whole is not being increased to reflect that.

So given that and given the fact that if you have budget neutral improvement for primary care, the remaining services are going to be limited it to 0.6 percent. I would hope you would consider going back and rethinking the productivity piece.

MS. GRAHAM: I'm Emily Graham from the American

Society of Cataract and Refractive Surgery, and I'm pretty much going to echo some of the same comments that Sharon McIlrath made with regard to the productivity adjustment and the MEI.

We are also concerned that the 1.1 percent update won't cover the practice costs increases in 2010, because the formula used to calculate those understates the actual cost of providing care.

As you know, the price proxies used in the MEI are based on how medical care was delivered in 1973 and not how it's being practiced today. There hasn't been any adjustment for the implementation of technology nor has there been any adjustment for the increases in the number and type of staff that physicians must employ these days to comply with the mountain of regulations that have been issued over the past several years, not to mention the number of CMS initiatives that they have in place to audit claims and things of that nature, and also the programs to reduce fraud and abuse, such as the recovery audit contractors. Those require specialized have.

We're also concerned about the productivity adjustment. As you know, not all physicians can increase

their productivity. If they do and volume increases that causes a problem in the SGR. Many times when there are efficiencies, those efficiencies are usually the result of the work being performed by those staff who have not been accounted for in the MEI. So, we would also ask that you reconsider the productivity piece and that you would weight it for physicians.

We would also share the same concerns that were voiced by the ASC community, because a number of our physicians also have a significant interest in ambulatory surgical centers.

Thank you.

MR. HACKBARTH: We will reconvene at 1:45.

[Whereupon, at 12:47 p.m., the meeting was recessed, to reconvene at 1:45 p.m. this same day.]

AFTERNOON SESSION [1:47 p.m.]

MR. HACKBARTH: First up this afternoon is Nancy, who is going to lead us in a discussion of dialysis.

MS. RAY: Good afternoon.

There are more than 300,000 dialysis patients in the U.S. Most of these patients are covered by Medicare. Thus, how Medicare pays for outpatient dialysis services is relevant to their care.

My presentation is composed of two parts. First, I will provide you with information to help support your assessment of the adequacy of Medicare's payment for dialysis services. Second, I will present a draft recommendation for you to consider about updating the composite rate for 2010.

So here are the six payment adequacy factors that we will be discussing, and much the same as what you saw this morning.

Moving to beneficiaries' access to care, it appears to be good for most beneficiaries. There has been a net increase of about 160 facilities between 2007 and 2008. There has also been a net increase of about 2,800 hemodialysis patients. The hemodialysis stations are the

machines where people are dialyzed. The number of hemodialysis stations appears to be keeping pace with the growth of the patient population.

Next month, we hope to show you an analysis of whether providers have changed the mix of patients that they treat. For example, the demographic characteristics and the clinical characteristics of patients. This is important because from this analysis we look at whether certain types of patients are having access problems. In last year's report we did not find any changes between 2005 and 2006.

There are about 4,900 dialysis facilities in the U.S. Most providers are freestanding and for-profit, and about 60 percent of all facilities, and 70 percent of all freestanding facilities, are affiliated with two national large chains.

Here you see a slide showing that the two largest chains, which are the pink dot, operate in most states. Together these chains operate in about 47 states. Of the remaining facilities, about 30 percent are freestanding facilities -- that's the upside down green triangle -- and about 10 percent are hospital-based. That's the yellow diamond.

We have looked at a number of pieces of information about changes in the volume of services and payments for dialysis services. First, we see that the growth in the number of dialysis treatments has kept pace with the growth in the patient population. However, spending patterns have changed. Expenditures for composite rate services -- that is for the dialysis treatment -- have increased, while expenditures for separately billable dialysis drugs have decreased since 2005. Why? Because of changes mandated by the Congress in the MMA and also because of changes in the volume of epo furnished to patients.

First, let's talk about the MMA. The MMA decreased the payment rate for separately billable dialysis drugs. Medicare currently pays ASP plus 6 percent for dialysis drugs. The MMA increased the composite rate by shifting some of the profits associated with drugs to an add-on payment of the composite rate. The add-on payment was 14.9 percent in 2007.

Here you see the change in the growth patterns for dialysis services. The red line represents both payments for composite rate services and separately billable drugs. The yellow line represents spending for composite rate

services, that's the dialysis treatment. The green line represents spending for erythropoietin, a drug used to treat anemia, and the blue line represents spending for all other separately billable drugs.

You will see that spending continues to grow in the post-MMA period -- that is between 2005, 2006, 2007 -- but at a slower rate than pre-MMA, 1996 to 2004.

The other reason for the slowdown in spending growth is the trends in the volume of epo furnished to patients have changed. Between 2005 and 2006 the total volume of erythropoietin plateaued, remained about the same. And between 2006 and 2007 there was a slight decline in aggregate by about 1 percent, at least according to our preliminary analysis.

There are two reasons for this slight decline in volume. The first is that in 2006 CMS implemented a modified payment policy. It's called the epo monitoring policy. Since April 2006, the Agency reduces providers' payments for erythropoietin if patient's hemoglobin levels exceed a certain level.

The second reason is over the past several years there has been new evidence published in peer-reviewed

journals that have showed that high doses of epo have had negative side effects on patients. In 2007, the FDA issued a black box warning on the epo label.

We look at a variety of measures to assess changes in dialysis quality. For some measures, dialysis outcomes remain high or they continue to improve. Quality is moving in the right direction for hemodialysis adequacy, which measures how well the dialysis procedure cleans the patient's blood. A high proportion of patients are receiving adequate hemodialysis.

Quality is also moving in the right direction for anemia management. The proportion of patients with their anemia under control also remains high and has increased during the past five year period. The use of AV fistulas, the recommended type of vascular access, the site on the patients' body where blood is removed and returned during hemodialysis, has increased since 2001.

Patients' nutritional status has shown little improvement over time. This is of concern because in dialysis patients researchers have linked poor nutritional status to higher rates of hospitalization and mortality.

I would like to point out that the measure that is

used to track nutritional status can also be affected by other conditions, such as inflammation.

Finally, we also looked at aggregate rates of hospitalization and mortality. Rates remain high for dialysis patients. However, data show some decline in mortality rates since 2001 and hospitalization rates show a drop between 2005 and 2006.

Regarding access to capital, indicators suggest it is adequate. We have not found any evidence that the two largest chains have experienced any problems during the recent changes to the financial credit markets. According to stock analysts, both companies have strong balance sheets including cash flow. Remember, I told you that these two chains account for about 60 percent of all dialysis facilities. In this sector, we see an increase in the number of facilities. Providers, even smaller providers, appear to have access to private capital to fund acquisitions.

So here is the Medicare margin. This is for both composite rate services and separately billable dialysis drugs. It was 4.9 percent in 2007 and we project it will be 0.7 percent in 2009. The reasons for the margin to fall

between 2007 and 2009 are that drugs remain profitable but the volume of erythropoietin is declining. Average cost per treatment for composite rate services grew by about 3 percent since 2000. And regarding the update to the composite rate, there was not an update in 2008 but the Congress did increase the composite rate by 1 percent in 2009.

We do find differences in the 2007 actual margin by provider type. This is consistent with last year's finding, as well. It was substantially larger for the two largest chains than for everybody else. This difference reflects differences in the drugs' profitability between these provider groups and the lower costs per treatment. Chains get better pricing for drugs than non-chains and the efficiencies of scale result in lower composite rate cost per treatment for the two largest dialysis providers. The 2007 margin was also about two points higher for urban facilities than for rural facilities.

The second part of our update process is to consider cost changes in the payment year we are making a recommendation for, 2010. CMS's ESRD market basket projects providers' costs will increase by 2.5 percent in 2010. As

in the case with other provider groups, we consider the Commission's policy goal to create incentives for efficiency. So the chairman has decided to start this discussion with last year's recommendation, and that is that the Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less the adjustment for productivity growth for calendar year 2010, concurrent with implementation of a quality incentive program.

Based on the current market basket of 2.5 percent and the Commission's expectation for productivity growth of 1.3 percent, this recommendation would be an update of 1.2 percent. Note that there is a provision in current law for a 1 percent update of the composite rate in 2010, so this recommendation is very close to current law.

That concludes my current presentation and I look forward to your discussion.

MR. HACKBARTH: Well done, Nancy. I need a show of hands with round one clarifying questions.

DR. CHERNEW: I have a really simple question, since this is the first time I've gone through this and this has come up before. When there are statements like would

increase beneficiary cost-sharing, the word increase in that is relative to current, so it's relative to basically a zero baseline as opposed to some other one?

That's just the way --

DR. MARK MILLER: It's relative to current law baseline.

DR. CHERNEW: So current law baseline now...

DR. MARK MILLER: Whatever increases are occurring under current law which assumes, I picked this up halfway through the question...

MS. RAY: Current law right now is 1 percent in 2010.

DR. MARK MILLER: So if we gave anything above that, then that is additional cost for the program and for the bene.

DR. CHERNEW: So the market basket minus productivity estimates now are slightly higher in the end of that, and so that ...

MS. BEHROOZI: Thanks very much. I told Nancy how I was reading the paper with interest, but there might have been something that I missed in it.

In the paper you referred to the growth in cost

per treatment in between 2000 and 2007 partly stems from rising general and administrative costs which increased by 9 percent per year for about 30 percent of the total cost per treatment in 2007.

What's included in general and admin, because I see capital and labor is separate. Does that include profit? Sometimes that's a euphemism for excess money.

MS. RAY: G and A would include costs that are not covered by capital, labor or other direct. Let me get a better answer for you at the next Commission meeting about that.

MR. GEORGE MILLER: Thank you. Just a technical question if you could help me with the difference between the urban facilities and the rural facilities. I think you said there was a 2 percent difference in margin? That's your slide 13.

MS. RAY: Yes, and the -- yes.

MR. GEORGE MILLER: Can you help me then differentiate -- you said there are two major players and they have 60 percent of the market. Where are they located geographically or distributed? How much of that percentage affects the rural facilities versus those that are run by

those two large chains?

MS. RAY: That's a good question. I can get back to you in January about the exact percent of their penetration in urban versus rural areas. What I can say is off the top of my head they are in rural areas, however.

MR. GEORGE MILLER: Do you know the ratio?

MS. RAY: I will get back to you in January.

MR. HACKBARTH: I think what George is suggesting is maybe one reason for the difference is the location of the chains, that they're more likely to be located in urban while the stand-alone are more likely in rural. And you're saying well, there may be some of that but you're not sure, you need to check.

What would be other potential explanations for the urban/rural margin difference? These are urban and rural differences for freestanding and not hospital-based, right?

MS. RAY: That's correct. This is just -- the map that you see in front of you includes hospital-based but the margin only includes freestanding facilities.

MR. HACKBARTH: So that's not a potential explanation of the urban/rural. What are some other factors that might play into it? Do you know, Nancy?

MS. RAY: That the rurals would have a lower margin?

MR. HACKBARTH: Yes, what that difference? Scale maybe?

MS. RAY: The scale, and if their use of dialysis drugs is less on average than facilities located in urban areas. Because, again, the profitable part of this is associated with the dialysis drugs.

DR. CASTELLANOS: I was just going to mention, I think a lot of it is economy of scale. What you're dialyzing four people, it's a lot more extensive than 10 people.

MS. HANSEN: It's almost such a simplistic question when I look at the map, and relative to all of those open spaces where there are no dialysis centers. What happens to people who do need dialysis there, just generally speaking? Because you can see the concentrations that are very deep. Is it by population? But what happens to those big emptier spaces? Do you know?

MS. RAY: I think that's a good question, number one.

Number two, we have not heard of any what I would

say either anecdotal or systematic problems with patients getting access to care.

I would imagine for patients who do live some distance from a dialysis facility -- and one alternative is, of course, home dialysis, and that could either be done via peritoneal dialysis or home hemodialysis. So those are two other options.

But I can double check the literature on your question.

DR. MARK MILLER: We can nail this down, and I think Nancy is always cautious before she answers something.

We assume that what's is happening here is travel. And when we talk to the industry in terms of access and those kinds of issues, we are not finding access problems. So it's not like people aren't getting dialyzed. It just means longer travel times in some instances, and then potentially alternative ways of doing it.

MR. HACKBARTH: So according to that map, there isn't any in Bend, Oregon. And between us and the purple sites on the map are the Cascade Mountains, which in the winter would be very difficult to travel four times a week for dialysis. So there must be some other alternative in

Bend, Oregon but I don't know what it is.

MS. RAY: I'll look into that.

MR. HACKBARTH: Any other clarifying questions or comments? Let's go to round two then. Let's see a show of hands of who has comments for round two.

DR. BORMAN: This was generally a very nice chapter and thought work, Nancy.

My question or suggestion might be as we look at criteria to evaluate going forward, one of the things, if we take a big view of the system and the patients, might be some measure of whether patients are being appropriately evaluated as candidates for transplantation. In the long run, a patient with a functioning transplant costs the system a whole lot less money than does ongoing dialysis and the patient has a better quality of life.

And so I think it might be important as we look for ways to introduce system-ness through quality and look in a very forward thinking way, and I'm pretty confident that the major societies involved -- I know the American Society for Transplant Surgeons has some thought about that.

I just think in addition to picking at some of these things like their albumin and all of that, where for

example if somebody has a kidney condition that got them to dialysis in which they lose protein in their urine, you can work pretty hard to get their albumin up. And the odds that it's ever going to happen is going to be pretty small.

So there might be a way to look at some other things that might be almost a more sophisticated measure.

DR. MARK MILLER: Just to make sure I understand what you're suggesting, you're saying that we should start a process of looking at eligibility for transplant because that's an alternative to spending --

DR. BORMAN: Right, and it would also be a measure sort of how is this working as a system program. Because there are certain people who aren't candidates for transplantation for a variety of reasons. That's one thing. But there's potentially -- not that I would mean to suggest that anyone would look at it this way -- but there's potentially more income to be derived from maintaining somebody on dialysis than there is getting them into the transplant world.

But on the medical quality side, which is sort of where I look at this, as an indicator of if that center is sending people appropriately for evaluation and getting them

transplanted, that suggests to me that probably their work with those patients is at a higher caliber work.

DR. MARK MILLER: And it had not occurred to me. I don't know if it had occurred to Nancy, but I think this is an interesting thought.

DR. CASTELLANOS: I think it's a good tip-in to what I wanted to talk about. It's something I brought up last year and it kind of goes to Karen's comments. If you get transplanted in the United States and you're under Medicare, you're covered for three years with your anti-rejection drugs. After three years, it's not covered by Medicare anymore.

What happens is people that can afford it and have the financial stability, they can continue on their drug. The people that don't have insurance or don't have the financial stability stop the drug, they lose the kidney, and then you go right back to the same cycle.

The reason I'm bringing this up is one of the comments Karen just made is in the private world -- I'm not talking university -- one of the big criterias we use to transplant patients -- and I've been involved in that -- is we look at their financial stability and their insurance.

And whether you like it or not, if you don't have good financial stability and insurance, you don't get transplanted.

There was a recent article I hope some of you may have read in the New York Times just recently where that point was well brought out, that the number of transplants that are done in the United States and the uninsured or poorly insured is significantly lower than the number of transplants that are done in the insured population. But even more striking is the number of patients that donate kidneys are much higher in the uninsured group than in the people with insurance.

So I think there is a very big disparity here. And I know we can't make world recommendations. But perhaps maybe in the topic we could suggest that maybe Medicare pays a little longer than the three years.

It's a savings to Medicare to save that person from going back on dialysis. That's my only point.

MR. GEORGE MILLER: Just a follow-up on the efficient provider, especially in dialysis. If you have a rural provider and an urban provider and a rural single provider, even if they're for-profit, if everything is equal

the cost of the drugs could be the difference because a larger provider or a large entity can buy their drugs at a larger unit of costs and savings. We then consider that more efficient than a rural provider who may have the same quality, do everything well, but cannot afford to buy the drugs at that same unit cost.

How do we handle that? I have a concern about that but I don't know how to address it. Is that just the luck of the situation? They're still providing the same service, and again the only differential would be the cost of that drug, the unit cost of drug.

MS. RAY: Let me start and then you take over.

What you see between the two large dialysis organizations in the other freestanding facilities is that they do get a better price for the dialysis drugs, as well as the composite rate cost per treatment is also lower. So I just wanted to point out that both of those are working at the same time.

Plus there is a slightly different -- the volume of drugs provided varies from provider to provider. I can get into that a little bit more, but that also plays in the margins that you see.

DR. MARK MILLER: [off mic] Just a reminder before I say this, this is ASP plus 6; right?

MS. RAY: Yes.

DR. MARK MILLER: Where I also thought you were going to go is part of the reason the 6 exists on the ASP is because everybody doesn't get it necessarily at the average.

MS. RAY: That is true and the OIG has looked at the purchase price for the two large dialysis chains and everybody else. And indeed, the OIG reported -- I forget it if was last year or the year before last, that they were indeed differences and that the two large dialysis chains were able to purchase drugs for a better price than everybody else.

DR. MARK MILLER: I'm sorry. So the point was when Medicare went to the -- ASP is average sales price; right? -- to the average sales price, the concern is that in an average some people get it above and some people get it below and there may be some people who systematically can't get it below the average. And that's why the add-on is...

MR. HACKBARTH: I think what George is pointing out is okay, that's the payment mechanism. What that may mean is that all providers are able to make a profit. But

you could still find that there is a differential profit level between the small freestanding and the big chains. And then, if you take the step of saying well, we need to squeeze the rates so that they reduce the profit margin to the level of the most efficient provider then there's still going to be differential pain, if you will, for the freestanding providers.

I agree with that chain of logic.

The only thing I would suggest is that you also need to take it the next step. If we say okay, what we're going to do is pay for higher levels for providers so that they can afford to pay higher drug costs, that money doesn't come from heaven. It means that it's got to come from taxpayers to finance what is a less efficient way of delivering the care. That doesn't mean it comes all from rich people. It comes from people who don't have health insurance. There are no free goods here.

MR. GEORGE MILLER: But I think, to Jay's point, a physician who is dealing with dialysis patients, he can't increase productivity much more because he's dealing with his hands and his skill level.

DR. MARK MILLER: I'm not saying that every

physician or facility can do this, but some of what Nancy is pointing out is that you do see increase in capacity, both in the numbers of dialysis suppliers and the numbers of stations inside a dialysis provider, which means that you can have more going on at any point in time.

The other point, to the exchange that you and Glenn had, sometimes in this exchange it gets to this point, which is we still have to think of the update whether -- if the exception your point is like look, in the remote rural areas there is going to be an economy of scale that is never going to be profitable, the things that you've said in the past in response to that is there may be an update question that needs to be answered and then a separate question as to whether there's something particular to do in that instance. For example, if there's an economy of scale issue.

And so I think sometimes that conversation occurs around this table.

MR. HACKBARTH: Thanks for raising this, George. These are important questions and they're not questions that have easy answers. What we have said in some sectors is well, to assure adequate access to a critical service you may want to change the payment method. In the hospital

world we've done a variety of different things, like critical access hospitals, et cetera. But MedPAC has also advocated for low volume adjustments to account for the inherently more limited opportunities that small institutions have.

Here, though, we may be talking about a different sort of problem where they could achieve these economies by affiliating with a chain. And what we want to do is pay more so they don't have to do that.

I know reasons for that and I know why some people feel uncomfortable about that. But again, the money doesn't come from heaven. It comes from taxpayers. And we have to have -- Arnie has spoken eloquently on what this burden means for real people. So tough choices, no easy answers.

MS. RAY: I just want to point out one other item. In 2011, when the broader bundle starts to be implemented, in that case Congress has mandated three adjustments -- and one of them is for facilities that are low volume and high cost, that the Secretary is required to implement. And then there is discretionary -- the Secretary has the discretion to implement other payment adjustments according to MIPPA, including one for rural facilities.

So I think as we move forward to modernizing the payment system, that's one of the issues I think that we can take on a little bit more.

MR. HACKBARTH: Let's go to the third and final round. It won't surprise you to hear me say that I'd like people to focus on the recommendation. And in particular, if there are people who have reservations about the draft recommendation, which is on page 11, I'd like to hear those now so that we can start thinking about them.

Any comments?

DR. STUART: I was taken by the drop in margin. As you know from my earlier comment, I had some qualms about margins. But in this particular industry, the Medicare margin is pretty much the margin. Is that right?

MS. RAY: Well, no, it's not, because commercial payers do pay -- are the primary payer for patients who -- when they are ESRD, the commercial payer is their primary payer. And the commercial payer remains the primary payer for the first 33 months and then Medicare becomes secondary.

So in that case, Medicare would be the secondary payer. So there is a fair percentage of patients where the commercial payers are the primary payer.

DR. STUART: What do those margins look like, if we're going to be comparing them?

MS. RAY: We don't analyze them. Information from stock analysts suggest that commercial payers do pay at a rate that's greater than Medicare.

MR. HACKBARTH: Others? What do people think about the recommendation? Any significant reservations, Bob?

DR. REISCHAUER: No, I have no reservations. I think it's fine.

But I want to go back to this chart that has the distribution of these centers. Does this is include everything? What if it was in a critical access hospital?

I'm looking at Oregon and I can't believe, there are people -- not many, but there are people living there. My daughter was one of them for a long time. She's a marathon runner, so she isn't in this. But Pendleton, La Grand, there's nothing anywhere close to them.

MS. RAY: We will get back to you on that.

[Laughter.]

DR. MARK MILLER: We will find your daughter and figure out what...

MR. HACKBARTH: Any others? Okay, thank you very much.

Next, we will move on to skilled nursing facilities, Carol.

DR. CARTER: We will be using our standard update framework to assess the adequacy of Medicare's payments for SNF services. We have discussed the design of the PPS in detail before and the paper summarizes the per diem payment so I won't go over that here.

In fiscal year 2008, spending for SNF services is projected to be 22.8 billion. That's the line in yellow. You can see that there was a large increase between 2006 and 2007 after the new highest payment case-mix groups were implemented in 2006.

The growth in spending is projected to slow down because CMS expects case-mix increases to taper off. On a fee-for-service enrollee basis -- that's in red -- spending increased slightly faster than overall spending.

The number of SNFs has been fairly steady for several years with just over 15,000 providers. On net there were seven fewer SNFs in 2008 than in 2007. The number of hospital-based units continues to decline, even though there

were a handful of units that opened during the year.

In terms of volume, after adjusting for the number of fee-for-service enrollees, between 2006 and 2007 there was a slight increase in covered days while admissions remained flat. There was a very small increase in the number of SNF users.

Turning to access, because Medicare is seen as a good payer in this sector, most beneficiaries appear to experience little or no delay in accessing SNF services, especially if they need rehabilitation care.

While access is good, some patients with medically complex care needs can experience delays in getting placed in a SNF while discharge planners find a SNF that is willing or able to take the patient.

The paper describes in more detail three trends we observe in service use. First, we see a growing concentration of special care and clinically complex admissions in fewer SNFs. Examples of these types of patients include patients who are dehydrated, have pneumonia or are on dialysis.

In 2006, we found fewer SNFs treated these patients and the top admitters accounted for a larger share

of these types of admissions than in 2002. This trend reflects the inequities of the payment system that underpays for medically complex cases and non-therapy ancillary services and overpays for therapy services which can result in patient selection.

Second, the rehabilitation days make up a growing share of days and the intensity of therapy services continues to increase. Rehab days made up 88 percent of all days in 2007 with days in the highest therapy groups growing the fastest. This trend reflects the incentives inherent in the PPS to furnish therapy services and the payment system's mismatch between therapy payments and therapy costs.

The third trend is a growing share of days that qualify for the rehabilitation plus extensive services groups, which have the highest payments. Days classified into these groups increased 33 percent between 2006 and 2007. This increase may reflect coding improvements by SNFs to record extensive services. Days are classified into these groups based on the patient assessment, which asks about services furnished in the past 14 days. For the first assessment this look-back period extends into the preceding hospitalization. And SNFs record the extensive services

that were furnished by the hospital. In these cases, the program has paid twice for these services, once in the hospital and again in the SNF.

To address these trends, you've made the following recommendations to change the way we pay for SNF care. First, you recommended that the SNF PPS be revised so that payments are targeted for non-therapy ancillary services and therapy payments are based on predict care needs, not service provision. These changes would increase payments for medically complex cases and lower payments for therapy days. The changes would also more closely match therapy payments to therapy costs. With more accurate payments, SNFs would have less financial incentive to select certain types of patients over others and less incentive to provide therapy care.

You also recommended that CMS gather information about services delivered since admission so that SNF payments could exclude the care furnished by the hospital.

Turning to quality, we used two measures to assess the quality of care furnished to SNF patients. Rates are risk-adjusted community discharge and potentially avoidable rehospitalizations for five conditions. Looking at the

seven year trends, we see a mixed performance. Risk adjusted rates of community discharge within 100 days declined, and then increased and in 2006 were the highest they've been since 2000, indicating improved quality.

In contrast, the risk adjusted re-hospitalizations have steadily increased throughout the period, indicating poor quality.

We continue to see differences by facility type and ownership. Hospital-based facilities look better on both quality measures compared to freestanding facilities after controlling for case-mix, ownership and location. For-profit facilities have mixed performance compared to nonprofit SNFs. They have higher community discharge rates, indicating slightly higher quality, compared to nonprofit SNFs but they also have higher potentially avoidable rehospitalizations, indicating poor quality.

Unmeasured case-mix differences and other factors could explain for some of these differences in quality.

Like in the other health care sectors, lending to nursing homes has slowed considerably due to the uncertainty and turmoil in the financial markets. Even though Medicare is a small share of most homes' revenues, it is seen as a

generous payer. Capital is expected to remain tight with lending restricted to financially strong institutions and those that have an established relationship with a lender. Capital, especially for small and medium-sized projects, will be available but will be more expensive and the terms will be more restrictive. But again, the tight access to capital is related to general lending trends and not the adequacy of Medicare payments. Medicare continues to be a preferred payer.

Comparing payments and costs, the aggregate Medicare margin for freestanding SNFs was 14.5 in 2007. This was the seventh year in a row that the margin was above 10 percent. This year's margin was higher than last year's, which was 13.1, reflecting payment increases that exceeded cost increases. There continues to be variation in the financial performance across facilities, ranging from over 4 percent for the nonprofit SNFs to over 17 percent for for-profit SNFs.

While half of freestanding SNFs had margins at or above 16 percent, one-quarter of SNFs had margins at or below 5 percent and one-quarter had margins of at least 25 percent. About 18 percent of SNFs had negative margins.

Not shown on this table, hospital-based facilities continued to have very negative margins, negative 84 percent. We have often discussed the reasons for the large differences in per day costs between hospital-based and freestanding facilities, including their higher staffing levels, unmeasured case-mix differences, the allocation of overhead from hospital, and different practice patterns.

The wide disparity in financial performance reflect the poor targeting and inequities in payment for different types of cases that exist in the current PPS. The differences in margins would be narrow if the recommended revisions to the PPS were implemented.

Here we compared freestanding SNFs in the top quartile of Medicare margins with those in the bottom quartile and we found that cost differences were larger than the differences in revenues. Case-mix adjusted costs per day were one-third lower, achieved in part by having higher average daily census and longer stays over which to spread their fixed costs. Unmeasured differences in case-mix could explain some of the cost differences between high and low-margin SNFs.

On the revenue side, high margin SNFs had a

smaller share of the less profitable medically complex days and a higher share of the rehabilitation plus extensive service days, the highest payment case-mix groups.

In modeling 2009 payments and costs, we consider the policy changes that went into effect between the year of our most current data -- that's 2007 -- and the year of the projected margin, 2009. Except for accounting for the full market basket updates for both years, there were no other policy changes to consider. In estimating the margin for 2009, we used the actual average annual cost increase over the past five years and not their market basket, which is lower. We did not factor in any behavioral offset that might increase payments. Our estimated margin for 2009 is 12.6 percent.

Before we discuss the Chairman's proposed recommendation, I wanted to note that the update is only one tool to help improve the accuracy and incentives of the payment system. Past recommendations, many of which I already mentioned, are aimed at increasing the accuracy of payments so that payments are more equitable. In addition to revising the PPS, you've recommended that the Secretary gather better information about service use, patient

diagnoses, and nursing costs.

Another recommendation was to link payments to beneficiary outcomes by establishing a quality incentive payment policy. You recommended using readmission rates as one of the measures to increase the coordination between sites.

Two recommendations were aimed at increasing our ability to assess the value of Medicare's purchases. You recommended improving the publicly reported quality measures and requiring that patient assessments be conducted at discharge so we can measure changes in patients' functional status.

This fall we discussed the need to improve care transitions between different sites. Over this coming spring and summer we plan to look at the cost of episodes of post-acute care across settings as a way to begin to think about bundled payments for post-acute care. We recognize the improvements in this sector need to be made along a number of dimensions and price is just one piece of that effort.

With that as context, we start the discussion of this year's update with the Chairman's draft recommendation,

which was the same as last year's. It reads: the Congress should eliminate the update to payment rates for skilled nursing facility rates for fiscal year 2010.

Given that margins were higher in 2007 than they were in 2006 and are more than adequate to accommodate cost growth, this continues to be, we think, a reasonable recommendation. This recommendation would lower program spending relative to current law by $250 million to $750 million for fiscal year 2010 and by $1 billion to $5 billion over five years. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

The paper also discusses two refinements to the revised redesign PPS you recommended last summer. Each deals with improving the accuracy for payments for days at both ends of the cost distribution, days with exceptionally low therapy costs, and stays with exceptionally high ancillary costs.

I'd be glad to answer any questions you have about those sections of the chapter. And with that, I look forward to your discussion.

MR. HACKBARTH: Thank you, Carol.

Could I see the hands of people that have clarifying questions?

DR. REISCHAUER: Carol, does the risk adjustment mechanism that's used to adjust the community discharge rate include any components that reflect the capability of the living arrangement that the patient has in the community?

DR. CARTER: No, it does not. Now I know what you're asking. No, it does not. It includes about six or so MDS measures and 15 or so diagnosis and comorbidity kinds of things.

DR. REISCHAUER: So presumably, that would explain a lot of variation?

DR. CARTER: That might, right.

MR. EBELER: Thank you for the presentation.

Remind me of two things. Is the negative margin for the hospital-based SNF included in the total margin estimates for hospitals that we looked at earlier?

DR. CARTER: Yes, it is.

MR. EBELER: Second, looking at our previous recommendation about accuracy and equity, did we presume that that would -- rebasing is probably the wrong word -- but recalibrating the payments at their current aggregate

level? Or was the presumption that in doing that we would be lowering payments overall?

DR. CARTER: When we modeled it we did it in a budget neutral way, so we didn't talk about the level of payment but really redistributing the payments that were in the system, really moving money from certain types of cases to other types of cases. But it was done in a budget neutral way.

MR. EBELER: Thank you.

MS. HANSEN: Also a bit of a follow-up on the same, slide nine, where we're talking about the discharge and re-hospitalization.

On the discharge component, is there any collection of data relative to re-hospitalizations after the 100 days? In other words, they're discharged to the community. But I just wondered -- especially the ones that are not normal rehab type of discharges but for other complex care -- whether or not there is a re-hospitalization follow-up beyond that 100 days?

DR. CARTER: We haven't looked at that but of course you could link the files and look further back if we wanted to do that. We looked at readmission rates within 30

days -- which is probably going the wrong direction from what your question suggests -- and 100 days. We haven't gone beyond that but we could.

MS. HANSEN: The reason for my asking that is on the one hand by itself, the fact that there are more discharges, it looks good. The certain discharges that would be probably normal that you would expect with a rehab discharge. But I'm always -- as you probably know -- interested in the more complex conditions and what happens to that population when they get discharged.

And then moving on to the other side of the bar, the quality and the re-hospitalizations for any of the five conditions. Are any of them at all connected to the CMS new rule of October 1 last year of the never events at all?

DR. CARTER: No, not specifically. They are things like UTI and sepsis and congestive heart failure, electrolyte imbalance and respiratory infections. So they're more diagnoses related.

MS. HANSEN: Thank you.

MR. GEORGE MILLER: Thank you. Just a quick question, I guess that hopefully is clarifying. And I may know the answer just looking at data on page four. But if

there's a recommendation not to have an update, and many of the hospital-based units close and just go away -- in fact, the last two hospitals I worked at we closed our SNF units. What will the impact be, particularly on -- as Jennie just pointed out -- clinically complex patients? Where will those patients go?

DR. CARTER: That is one of our concerns and we have noticed a drop. One thing I looked at which is in your paper is the number of SNFs that are willing and able to take these patients. There have been declines in the SNFs. There are fewer SNFs taking these patients.

I think -- and Craig did this work a couple of years ago. The decision for a hospital to close a SNF, it's a broader decision than just the margin for that SNF. Those units can benefit a hospital, in terms of shortening the hospital stay and moving those patients to a SNF.

So sometimes those decisions aren't based narrowly about the SNF performance but sort of how that unit fits into a broader mission and what's happening more broadly in the hospital.

MR. GEORGE MILLER: The data on the two hospitals that I ran, I would respectfully disagree with you. We

ended up taking care of more of the complex patients and we were just losing our shirt on them. We closed.

DR. CARTER: One of the refinements we want to do, that we would like implemented, is to redirect payments for the medically complex patients.

MR. HACKBARTH: So as opposed to, George, saying let's give everybody a higher update, including the ones who are doing quite well on the rehab patients, a better response to healthy institutions that are caring for the medically complex is to change the payment system so that they get their appropriate share of the dollars. We've made a recommendation along those lines.

MR. GEORGE MILLER: Thank you.

DR. MARK MILLER: On that particular point, I'm sorry just to keep this one going, but when we showed the distributional impacts of that change what we were doing the work several months ago, there was a large increase in payments for hospital-based SNFs, if I recall correctly.

DR. CARTER: Yes, I'm remembering about a 20 percent increase.

MR. HACKBARTH: And part of what I liked about it was it wasn't based on the institutional structure, the

organizational structure. It wasn't a higher payment for a hospital-based SNF. It was based on the complexity of the patients. And they ought to be paid more regardless of whether it's hospital-based or freestanding.

DR. CARTER: It just happened to shake out that way.

DR. CROSSON: Just a question for information. The draft recommendation results in a decrease according to current law and that projects, I think, a market basket update. Could you explain how that is? How far in the future is that projected? Is that just for 2010? The current law that suggests a market basket increase.

DR. CARTER: I think that the PPS for SNF has, the way it's currently in law, is that they get market basket --

DR. CROSSON: Permanently.

DR. CARTER: Right. It's not going to expire, if you will.

MR. HACKBARTH: Although there are cases where Congress will write in a specific update for fiscal years 2008 and 2009 as part of reaching a budget agreement and then it may revert to full market basket. But this particular one, this is the long-term market basket

increase.

DR. CHERNEW: This is actually a follow-up on George's question and a more broader question. When there are situations like this, when there's a series of other recommendations that I gather are still on the table but haven't yet been implemented and now we have another recommendation, should we view the incremental recommendation now as if it was done on top of the other recommendations that are on the table? Or should we view it as if the other recommendations on the table are not implemented and now we're just doing this?

DR. MARK MILLER: The way I would characterize what we're trying to do -- and if you're following the path here, we're trying to do this in a lot of our update statements.

It, in part, is in response to things Commissioners have said over several years of, you the update isn't the complete a problem. So the way I would characterize what we're trying to do is we're trying to say to the Congress you asked us for the update. Here's our recommendation for this year. And these are the other things that we say that you need to do. So we're trying to

think of this as a group of things we're asking the Congress to do.

DR. CHERNEW: I guess what I would say is the concern here, I think we recognize, there's two issues. There's the update and then there's the relative weights. We're making the recommendations simply separating those two and we worry about the consequences of one part or the other, particularly the update.

So if you're asking what one thinks of this update and if you're worried about, I think, some of the complex patient issues, the question is how much are you willing to risk, if you will, making it worse for the complex patients because they don't take one of our other recommendations?

MR. HACKBARTH: I second what Mark said and I think in this case, as in some of the others that we've discussed today, I think we ought to include in the chapter our previous recommendation in this case about changing the case-mix system and reiterate that.

DR. CARTER: We plan on --

MR. HACKBARTH: Let me just finish. I would suggest that we make it clear that this is an update recommendation that we are making in the context, including

that case-mix change.

I think it's important for us not to go down the alternative track that you've suggested, where they may not do that so we need to give higher updates for everybody. I think that leads to a real problem.

Many of our case-mix -- in fact all of our case-mix changes are redistributive changes. They take money from one and give it to somebody else, we think towards the goal of more fairly allocating our resources. Those are often politically painful things to do, to take away something from somebody and give it to somebody else.

If you offer the easy path of let's just throw more money at everybody, that's politically inviting. And so I like to encourage Congress to put the pressure on people to say in the industry you need to come up and support redistribution as opposed to just asking us to shower more money on the industry as a whole.

So I really would discourage to say oh, let's just increase the update because they may not do the redistribution. That's a real problem.

DR. REISCHAUER: But there's another alternative, which is to update only certain things, change the weights,

use the same amount of money and differential updates.

MR. HACKBARTH: Mathematically, that can work out to the same thing is differential updates. But what that means for the maintenance of the system in the long run is potentially a real hash.

DR. REISCHAUER: You're trying to make one-time adjustments to the relative payments made for complex cases versus simpler cases.

DR. CHERNEW: I do think it's worth saying how important the other recommendation is in light of this one.

MS. BEHROOZI: This is going to be a little wacky and it's a little related to what I said to Jack at lunch today about the physician update where in the dialysis update we say the market basket update, or whatever it is, coupled with a quality incentives program.

And in the prior physician update, the last time we did a physician update, we said and the Secretary should implement a confidential feedback reporting system. And it just feels like we should do that with every one of our updates so that on the screen, on the update page, in the boldfaced type, there is -- if nothing else -- a reiteration of what we've said before not just in the chapter but kind

of to show that it's conditional.

I'm trying to figure out how to do it in this one where we're not recommending an update, but you know, maybe it's something that people have talked about like a negative update unless you change the weights. Maybe that's a way to couple them.

I feel like that's kind of what people keep talking about, is why do we say it sometimes and not other times. Maybe we could figure a way to say it each time in connection with the updates.

MR. HACKBARTH: I think this is an important point and let us think some more about how to present things that we think are closely related and really ought to be done at the same time. Another approach -- and I'm not advocating this -- but I've thought some about is maybe what we ought to do is vote again, for example in this case, and reiterate our vote in favor of the case-mix change as a way of highlighting yes, we really think this is important, we think it ought to be done concurrent with this update.

But how many of these things you want to string together, I don't know.

Suffice to say your point is well taken. We

understand and let us think some more about how to do the packaging and presentation to get the point across.

I've lost track of what round we were on. I think we've done round one, so round two. Any additional comments or questions?

DR. BORMAN: Just a quick question to help me in my thinking. Could you refresh me -- because I think we've talked about it before -- just ballpark total margin in this sector? We've had more margin conversation then I can certainly understand today, but just so that I have a balance of information, since we've talked about total versus Medicare and other things.

DR. CARTER: It was 14.5, but it ranges.

DR. MARK MILLER: Is that what your question was? Or were you asking an all payer?

MR. HACKBARTH: Including Medicaid.

DR. MARK MILLER: I'm not sure we know.

DR. CARTER: I'm sorry. I haven't looked at that. I'm sorry.

DR. BORMAN: [off mic] [inaudible]

MR. HACKBARTH: Karen, as you know, this has been an issue of concern in the industry, that we look at the

Medicare specific margin. For the benefit of the new Commissioners, let me just spend a minute on this.

We do look -- for all the sectors, not just SNF -- at the Medicare margin. It's been a particular issue here because of the Medicaid payment rates, which the SNF providers believe are inadequate and too low. Frankly, they look to Medicare to cross-subsidize their low Medicaid payment rates.

So for as long as I've been on the Commission, they've argued that we ought to look at total margin, not Medicare margin alone.

I disagree with that, respectfully, because I don't see increasing Medicare payment rates as a proper solution for low Medicaid rates, even if we stipulate that they're too low, and not everybody would agree with that stipulation.

If you increased Medicare rates to offset Medicaid underpayment, the institutions that get the most additional dollars are going to be the ones that have the most Medicare patients and the fewest Medicaid patients. So the money is not going to be targeted to the people who have the biggest Medicaid problem. It's going to go most to the institutions

that are caring for the most Medicare patients. So the targeting just isn't right. It's not a proper solution to the problem.

There is the related issue, also, if the Federal government says oh, it's our responsibility to assure the financial adequacy for the whole SNF industry, what does that then mean for this states? That seems like an open door to let's reduce our payment because the Feds have already said they're going to make up the difference. So increasing Medicare rates for a Medicaid problem just is not a very attractive solution.

DR. BORMAN: Just to clarify, I wasn't proposing that at all. I was just trying to line up the parallel number of columns in my mind. It would just be an interesting piece to fill in.

Thank you.

DR. MARK MILLER: The only thing I want to do in terms of setting expectations, if we don't have the data to estimate that directly -- it's my understanding -- we kind of hunt for it and see if we can find statements of it by other actors; is that right?

DR. CARTER: I'll look and see. I think we have

the data. I'll look and see.

MR. BUTLER: I think this is one of our most difficult areas because it's such key linchpin in the management of the fragile elderly population. We all know instances where it's difficult to have a successful thriving business, so to speak, and part of it is the Medicaid payments.

Having said that, I'm in favor of the recommendation. And with respect to the hospital-based piece of this, it will be helped some by the complexity. And I think that is the right way to do it, not just to give them a different kind of update.

But having said that, I think this is a dying breed. It's going to go away anyway. It's going to go away quickly in hospital-based. And maybe that's okay in the sense that the margins are, no matter how you slice this and no matter how you look at the whole, even on the margin this is not coming close to covering even the incremental cost. You can take shorter length of stay, all of those things. So as the financial pressures grow, it's going to get out of the business.

To some extent, it's correct. Retaining and

recruiting a nurse and using your same salary scales, it is different in a hospital. It is more expensive. I think there's better quality, but maybe that's something we just can't afford and we're not going to be able to do as cost-effectively in hospitals.

It's headed towards a for-profit freestanding business. That's the consequences of this. But I can't really say that I'm not sure in the hospital side we will be able to do it really cost-effectively. And yes, we should get paid more for the complexity of the patients that are there, but this thing is, I think, going to run its course where basically you're not going to have hospital-based units and we just ought to acknowledge that that's a likely consequence.

MR. HACKBARTH: Carol or Mark, could you remind us of the status of our prior recommendation? It requires a legislative change or is it a regulatory change to do the case-mix?

DR. CARTER: I don't think it requires a Congressional change but that is where we directed our recommendation. I think that's right.

DR. MARK MILLER: Because often if you have the

Congress direct the Secretary to do it, since that's kind of our point of influence. Sometimes we say directly to the Secretary, but sometimes we say that there needs to be a little urging.

DR. CARTER: I think CMS does need authority for an outlier policy but not for a change in the case-mix.

MR. HACKBARTH: What have we heard in terms of Congressional response to our recommendation?

DR. MARK MILLER: There has decidedly been discussions with staff and on some of the committees there is interest in this.

Carol, am I correct in saying that also you've gotten inquiries from CMS asking about the analysis and that type of thing?

DR. CARTER: Yes. And I know, since they are busy working with the -- they recently collected therapy and nursing time. And they're sort of revisiting a whole range of things. None of us have seen what their exactly working on, but I think they're working at a whole range of things.

DR. STUART: Carol, could you go back to slide four? You mentioned, and it's in the chapter as well, that between 2006 and 2008 or 2007 and 2008, that there are seven

fewer facilities. I'm assuming that that doesn't mean that they're all the same facilities? In other words, that there were just 7 percent that added on or were failed?

In other words, do you have any information in terms of the number of facilities that have opened and closed over this period of time?

DR. CARTER: I think there were about 100 that opened and 60 percent of them about were for-profit. I could get back to you about the specifics. There's some movement in and out.

DR. STUART: The reason I asked that question is that in any functioning market you would expect that there would be a number -- I don't know what the right number is -- that would close because they're bad actors and they don't perform well. And then there would be others that would come into the market because they see some activity.

In fact, if it was just stable, if there were very few openings and very few closings, then that would suggest that there's something wrong with this market because certainly we've heard a lot about bad actors. And that's another question that I had in a moment.

But I'd like to point up the point that Glenn made

about well, we don't want to use Medicare to fix the whole system. You could be a little schizophrenic on that. I mean, if you were the new Secretary of HHS and you have to deal with both Medicaid and Medicare -- and even though I agree with you philosophically, I think that somewhere in this chapter it would behoove us to say that we think that there are problems in this other area, even though we haven't investigated them, and make the point that we don't think Medicare policy is the mechanism by which we change these others.

But it's obvious if you look at the trend or non-trend that there is something else that's really wrong with this industry because if the margins were anywhere near, the total margins were anywhere near the Medicare margins, this industry would be exploding. In other words, there would be all kinds of new entrants trying to get into this industry.

So what that tells me is that entrants are unable to achieve a very high SNF population. They just simply can't develop policies so that they only get the high profit SNF patients. And their being dragged down, their profitability is being dragged down by the rest of the

patient load. Because otherwise it's just not consistent with having a flat supply.

DR. SCANLON: This isn't a normal market, and it's primary a function of what states have done. You've got a number of states that have had moratoriums on nursing home openings for 20 years or more. And over the last 20 years we've seen a decline relative to projections of 1 million beds, in terms of the number of nursing beds that appeared.

So I'm thinking that in part what we're seeing here is if you've got a license to have a nursing home, you hold onto it because you know that it's going to have value over time.

There's no question that Medicare is the best payer probably at this point in time between Medicare and Medicaid. Where a private resident is, though, that's another story completely. They're going to be less intense in terms of the kind of services they need and potentially even more profitable for homes.

I don't read a lot into this, in part because we've got these state policies dominating this for a major portion of the country. So it's kind of a function of that as opposed to market forces.

DR. STUART: If that's true, then it would be really useful in this chapter to make that point and then also to examine perhaps differences in supply response in states that don't have those restrictions compared to states that do.

MR. EBELER: I thought Mike, in the last round, asked the critical question, how do we link these recommendations? I do think that if you start with our substantive policy recommendation of really getting the accuracy and equity of payments much better -- and I think the work that you all did makes us pretty confident about that -- and that included a pay for quality program, as I look at this doing that with a zero update in total you can feel fairly confident of, given what we see here in the Medicare side of things.

In fact, if you think about that in the context of pay for quality, in general everybody would get a little less than that, you'd recalibrate that's to a little bit of a negative number and then pay it back with the quality incentive would be what the net impact of all of that would be, which it strikes me would be a valuable message for this field.

DR. CHERNEW: My concern has to do with moving out past 2010 with the changing demographics, what the needs in the future are going to be as we go forward capacity-wise. I understand there's issues with what states have done and issues with what Medicaid has done.

But I'm curious at least now as to what's the occupancy? And although I'm supportive enough of the recommendation, I think it would be useful enough to know somewhere that there is a real issue related to -- I think, and again I could be wrong -- a real issue related to demand for SNF services moving several years out as the demographics change that we haven't thought through.

And depending on what we think of not just the number of SNFs but the occupancy and the capacity of them, how we're going to manage that. I do think there's this complex bargaining thing going on between Medicare and Medicaid as to how that's going to get financed.

But that doesn't deny the fact that I think the chapter should discuss the volume needs for clinical reasons are likely to change over time. Maybe you have thoughts on that?

DR. CARTER: The occupancy rates are high.

They've come down a little bit in the last couple of years but they're high 80s, low 90s. And you know that there is a prior hospitalization requirement, so you do need to -- it's true as our population ages and more folks get hospitalizations, then they can use SNF services. But they're not quite as easy to access as other services without that prior hospitalization.

But I think your question is a good one down the road, is this an industry that can expand to meet the demand?

I guess I should add, one thing we've not done is just look at beds, since a bed is not necessarily just a Medicare bed. So it's harder to measure how big is this industry because a bed count doesn't really do it since the bed could be on Medicare bed today and a Medicaid bed tomorrow. But I think your question is a good what about down the road what is the supply and availability like.

MS. HANSEN: My comment is very closely aligned, again similar to the growing population of the 85-plus that I've have noted in the past tends to be -- actually, is the fastest growing subset and consequently has been proportionally a lot more hospitalizations and complexity.

I wonder if in the description, Carol, of the complexity we could describe perhaps some prototypical profiles of these complex people who are not able to get into facilities, just a little bit more texture to that.

And then also just -- and some of you recall I've said this in previous times relative to not so much the bed being defined Medicare or Medicaid, but the person being dual eligible. Oftentimes the costs kind of go bouncing back and forth.

Bruce, I think your comment about bookmarking somehow the Medicaid side, even though I'm very clear -- I think, Glenn, you've socialized me very well that this is a Medicare Commission. But the fact of the individual still being a dual eligible is the same individual. And there are some complexities there that I think are yet to be really understood.

It's not about the bed, it's about the person. And that's kind of a profile I'd like to keep front and center as the beneficiary. And there are many ways to care for a person who's complexly ill who happens to be a dual eligible other than using a nursing home bed. So we have to really begin to project out for modeling in the future.

Of course, it's still about the Medicare expenditures right now.

DR. SCANLON: First off, in relation to Mike's comment, the occupancy rate these days are actually much lower than they were in the late '80s or early '90s. Part of that relates to the fact that we've had the development of the assisted living sector, which essentially has become a second source of residential long-term care.

So I can see here in this sector, the skilled nursing facilities, that you could absorb a very large increase in terms of skilled nursing facility patients over time as assisted living takes care of the more custodial type of resident that has traditionally been in nursing homes.

I guess I'm not, at this stage, worried too much about the supply over the next 10 to 15 years.

The other thing I'd bring up is this question of linking some of our recommendations to pay for performance. Given that we've seen this issue of the problem of placing clinically complex patients, I'd want to put in a caution about making sure that in doing pay-for-performance we don't exacerbate the placement of difficulties for those people.

Because again, our performance measures are specifically based upon improvement as opposed to good maintenance for some who's not going to improve or someone who's actually going to deteriorate.

So I think it's one of those things where this is a very particular area of concern with that kind of person.

MR. HACKBARTH: Well done, Carol. We're going to need to move ahead.

Next up is home health agencies.

MR. CHRISTMAN: Good afternoon. Today I'm going to take you through the home health as it relates to the six elements of our framework. I'm not going to walk through them. I think you are probably more than familiar with them by now.

Before we begin, let me give you a brief overview of the size of the home health benefit to place it in context. In 2007, over 9,400 home health agencies participated in Medicare. Medicare spent over $16 billion on home health benefits and served 3.1 million beneficiaries.

Our first issue is access, and this map should be familiar.

In 2008, 99 percent of beneficiaries lived in a ZIP code served by at least one home health agency and 97 percent lived in a ZIP code served by two or more agencies. Again, this is unchanged from previous years and suggests that beneficiaries have widespread access to home health.

Also, as in previous years, the supply of providers and the number of fee-for-service beneficiaries using home health continues to increase.

The number of Medicare beneficiaries using home health increased 16 percent over the last five years. As you can see from the top line in this chart, the number of users rose in 2006 to 3 million and to 3.1 million in 2007. The growth in users in these two years is particularly striking because the number of beneficiaries enrolled in fee-for-service in these years, actually declined. That the number of home health users would continue to increase despite the shrinking fee-for-service population is surprising.

Given this rise in users the share of fee-for-service beneficiaries using home health rose to 8.9 percent in 2007 and the supply of agencies has increased in tandem with users. Over the last five years, the number of

agencies has increased by about 30 percent and the number of agencies per 10,000 beneficiaries increased by 22 percent.

For 2007, the trends in the types of agencies entering are unchanged from previous years. Most are for-profit and most are concentrated in a few states.

Concerns about concentration has led CMS to launch efforts to curb fraud and abuse. CMS began efforts in 2007 in L.A. and Houston and recently expanded these efforts to Miami-Dade County in Florida. In this area, there has been a surge in the number of agencies claiming outlier patients for high-cost episodes. For example, in 2007 over 60 percent of all outlier payments in the country were made to agencies in this area. For 200 agencies in South Florida, 50 percent or more of their payments were for outlier patients. This is far beyond the norm, with outliers consisting of 3 percent or less of episodes for most freestanding agencies.

CMS is taking a number of steps because of the magnitude of this anomaly. It has suspended payments for the 10 highest billing agencies in this region and is reviewing previously paid outlier claims in South Florida. For future outlier payments, agencies in this area that

submit outlier claims which exceed 5 percent of their total Medicare payments will be subject to review, and CMS is also conducting inspections of all the agencies in the Miami-Dade area.

Nationwide, the rapid growth in the number of agencies has caused CMS to change the priorities for state certification agencies to focus on enforcement. CMS has instructed state survey agencies to focus their efforts on responding to complaints and recertifications and, consequently, some states, including Texas, are not certifying new agencies. However, this is not a moratorium on new agencies. Providers that wish to participate in Medicare can do so by completing a survey with a private accreditation agency which Medicare will accept in the place of a review by a state survey agency.

The history of Medicare's payment and agency supplies suggests that Medicare's payment levels can drive agency apply. This graph shows how total spending in agency supply have changed over the last 13 years. The table along the bottom shows the payment system that was in effect for the different periods, X axis of the graph. In the early to mid-1990s, spending and the number of agencies grew rapidly,

as the benefit was expanded and agencies were subject to cost-based per-visit reimbursement with relatively few limits. And then concerns about excessive growth and fraud and abuse led to a reduction in 1997 in the BBA.

The interim payment system went into effect at the end of 1997 and set strict limits for the number of visits Medicare would pay for. The changes caused total payments and the supply of providers to drop rapidly. Spending dropped by 50 percent in 1998, the first full year these limits were in effect, and the number of agencies fell by about 360.

Spending and the number of agencies continued to decline until the IPS ended in 2000 and was replaced by prospective payment which has offered double-digit margins since its inception. Under the higher payments in PPS, total spending has risen by about 9 percent per year, and the number of providers has increased by an average of 300 per year. This pattern suggests that agencies are sensitive to the incentive in Medicare's payment systems and that higher payments can lead to more participating agencies.

Overall, home health agencies appear to have adequate access to capital despite the current credit

crisis. It is worth noting that home health agencies, even publicly traded ones, are less capital intensive than other health care providers, as they do not have to build a physical plant that a hospital or a skilled nursing facility may require. That said, agencies meet their capital needs in a variety of ways. Many agencies, typically the smaller or midsized, are able to borrow against their receivables, such as their projected Medicare payments, to meet their credit needs. The large for-profit publicly traded companies access capital through a variety of credit facilities such as loans, bonds, and revolving credit lines, and so far the tightening of the credit market has not affected significantly.

Going forward, the industry anticipates a challenging credit market, but they do not believe that any of their business operations or strategies will need to change as a result of the current turmoil. They still expect to acquire the capital needed for expansion through a combination of free cash flow from current revenues and their current credit facilities. And for the industry as a whole, the entry of new providers suggests that agencies are finding the means to expand and that access to capital

remains adequate.

This next table shows risk-adjusted quality measures for home health, and with a few notable exceptions the table shows that they have gradually improved. For the first five measures, all measures of beneficiary functioning, such as the ability to get out of bed or bathe, the steadily rising lines indicate that there has been consistent increase in the number of beneficiaries who improved. The bottom blue line is the rate of hospitalization. A decline would indicate improvement for these measures. However, the rate of adverse events has not changed in many years, though there was a 1 percentage point increase in the rate of hospitalization in 2008.

This next slide explains some of the changes in volume that have occurred. The number of episodes has risen about 40 percent since 2002, reaching about 5.8 million. However, that growth has been unevenly distributed among episode types. Therapy-intensive episodes, those with 10 or more therapy visits, accounted for a significant share of the growth since 2001. Under the PPS in effect in 2001 through 2007, episodes with 10 or more therapy visits qualified for a payment increase that averaged about $2,300

in 2007. Agencies had an incentive to increase the number of therapy visits to hit the 10 visit mark to maximize the number of episodes that qualified for the payment increase. Given this increase, it should not be surprising that these types of episodes grew at about 12 percent a year in 2002 to 2006, or twice the rate of growth for all other episodes.

The higher rate of growth increased the share of episodes with 10 or more therapy visit from 23 percent in 2002 to 28 percent in 2007. Though growth in non-therapy episodes has slowed in recent years, it has not for therapy-intensive episodes. As a result, therapy-intensive episodes were the majority of new episodes in 2006 and 2007.

Under the PPS refinements implemented in 2008, the 10-visit threshold was replaced with a multiple-visit threshold that gradually increases payments across the range of therapy visits provided, eliminating the windfall that existed under the prior system.

This table shows the margins for different categories of providers. You can see that overall margins in 2007 are 16.6 percent for freestanding providers. However, as you can see for the lines below the top entry, there is significant variation. For example, the agency at

the 25th percentile had a margin of less than 3.1 percent, while the agency at the 75th percentile had a margin of 26.3 percent. This distribution is similar to previous years.

The patterns for margin by geography, type of control, and volume were similar to what we have seen margins for providers that serve both urban and rural areas, referred to as mixed here, had the highest margins. Rural areas had the lowest margins, but those margins were still 14 percent, where profit margins equaled 18.6 percent and the not-for-profits had a margin of 11.9 percent. These margin estimates are our starting point for estimating 2009 margins, and I would note that we only project margins for 2009 for freestanding providers. For hospital-based providers, these margins were included in those reported during the review of hospital payments earlier, averaged a margin of negative 4.5 percent in 2007.

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

There are two policy changes that we need to include in our modeling. The first of these is the payment adjustment for changes in coding practice since PPS was implemented in 2000. CMS found that about 90 percent of the

changes in coding mix between 2000, excuse me -- 90 percent of the change in case-mix between 2000 and 2005 was for reasons related to changes in coding practice not changes in patient severity. As a result, their analysis showed that the current case-mix overstates severity by about 11.8 percent. CMS implemented a four-year adjustment to reduce payment level to a level that is commensurate with patient severity. The adjustment is about a negative 2.75 percent a year over four years.

The first of these reductions took place in 2008, and additional reductions will occur in 2009 and 2010 and our margin estimates will include the impact of these adjustments.

Another factor affecting payments in 2009 is the implementation of refinements to PPS that began earlier this year. These refinements substantially expand the role of coding practice and service patterns in payment. For example, the number of diagnostic conditions that affect payment is expanding from four categories to 22. We expect agencies to alter their coding practices as a result of the changes, and based on CMS's estimates of coding change that I discussed on the previous slide, we anticipate this will

raise the payment by 1.6 percent in 2008 and 2009.

With those assumptions for 2009, we turn our attention to the market basket. Now, in 2008, agencies got the full market basket increase, but this was offset by the coding adjustment I mentioned earlier. In 2009, we have much the same situation. Agencies will get a 2.9 percent increase in the market basket, but this will be offset by a negative 2.75 percent adjustment for changes in coding practice, and so there will be a net increase in the base rate of about one-tenth of 1 percent.

We found that costs grew by less than 1 percent -- excuse me -- we found that costs per episode grew by less than 1 percent in 2007 and, on average, cost growth has been about 1.5 percent a year since 2001, significantly lower than the market basket. However, cost growth in recent years has been erratic, with growth been about 1 percent in 2005, 3.6 percent in 2006, and less than 1 percent in 2007. To be conservative, we assume market basket, or 2.9 percent, in 2009. With these assumptions, we estimate the margins for 2009 at 12.2 percent.

In summary, access to care is nearly universal, with most beneficiaries having a number of providers

available. Quality is improving on most indicators and the supply of providers and the share of users continues to increase. Cost growth continues to be low, and with this information, we now turn to a draft recommendation for 2010.

To start your deliberations, this is a draft recommendation based on our recommendation from last year. It reads, The Congress should eliminate the update to payments for home health care services for calendar year 2010. We estimate that this recommendation would reduce spending by $250 million to $750 million in 2010 and $1 to $5 billion over 10 years. We expect it would have no adverse impact on beneficiaries or providers' willingness to deliver care.

What I have just presented is the Chairman's draft recommendation for 2010. Some Commissioners have suggested that home health payments are more than adequate and that providers could absorb cost increases, even with a decrease in Medicare reimbursement. I am now going to present an alternative recommendation that explores this approach.

Payment substantially in excess of costs have been a feature of home health since the implementation of PPS. This suggests that the initial level that payment was set at

was too high. One factor may be that the utilization, the number of visits per episode under PPS, is significantly lower than what CMS assumed when initial rates were set.

This slide explains the magnitude of that difference. When setting the initial rates for the PPS, CMS relied upon data about the number of visits that occurred in 1998, which equaled 31.6 visits. However, the average number of visits dropped between 1998 and the implementation of PPS to about 21.8 visits, about equal to the average of 22 visits in 2007. The difference between the visit level included in the base rate calculation and the level actually provided under PPS means that the actual cost for an episode is significantly lower than what was assumed when the base rate was set. Because providers deliver fewer visits than assumed, the payments under PPS have been consistently greater than provider costs.

A significant change in visits illustrates that the home health service is fungible and that agencies can dramatically change the content and level of service when the payment incentive changes. Prior to PPS, agencies had an incentive to maximize the number of visits they provided. PPS has different incentives because payment is based on a

beneficiary's characteristics and not the number of services provided, in most cases. Agencies have reacted, as expected, by decreasing the number of visits and increasing the number of episodes. Despite concerns about stinting, the change in visits had no detrimental impact on quality.

MedPAC and others have found that the quality provided under PPS was equal to the care provided during the period of the interim payment system in the late 1990s. That quality was maintained, despite a 30-percent decline in visits per episode, and further demonstrates the malleable nature of the benefit as agencies manage to deliver the same quality with significantly fewer visits. If the base rate set in 2000 had reflected the number of visits delivered under PPS, the rates today would be 20 percent lower than it actually was.

Another factor to consider is how the elimination of the market basket affected home health agencies the last time it was implemented. In 2006, the DRA eliminated the market basket and rates were frozen at 2005 levels for that year. However, as you can see, even with this freeze, the margin for freestanding agencies was 15.8 percent. Much of the decline was recovered in the following year when they

received the full market basket update. It should also be noted that average payment per episode increased this year by 4.5 percent, even though the rates were frozen at the 2005 level. Payments increased because of rising case-mix and an increase in outlier claims, in addition to a growth in the number of episodes that qualified for a full episode payment.

This brings me to the alternative recommendation. For these reasons, the Commission might conclude that providers may be able to absorb cost increases in 2009 even with a decrease in payments. While our draft recommendation would freeze rates for 2010 at the 2009, this policy alternative would lower them below the 2009 level. Lower rates could raise concerns that providers would reduce services to lower their costs. There are two measures we can include that would counter the incentive to curb visits. First, the recommendation could include a policy that would require the Secretary to implement a quality incentive that adjusts payments that have high rates of adverse events. Under this policy, agencies would have an incentive to minimize the rate of hospitalization and emergency department use by their patients.

Second, the recommendation could also include a policy that would adjust payments for episodes that have significantly fewer than average visits. This would be similar to policies in other areas such as long-term acute care hospitals and the in-patient PPS that prorate payments for short stays.

Here is how the alternative policy option would look: reduce rates for home health care services from the 2009 level by 5 percent for calendar year 2010. We would include a text discussion of the efforts to protect beneficiary care, such as an adverse event measure and a per-visit payment increase that would raise payment as the visits in an episode increases.

The spending implications are that we would expect us to reduce spending by $1 to $5 billion in 2010 and $5 to $10 billion over 20 years.

This completes my presentation. I look forward to the discussion.

MR. HACKBARTH: Thank you, Evan. Could I see hands for clarifying questions.

DR. CROSSON: Thank you, Evan. On the draft recommendation on page 16, if I understood the math

correctly, what that says is that were we to vote for this recommendation, we would be eliminating the update and that update 0.15. So is this net of the 2.75-percent reduction?

MR. CHRISTMAN: Right. What that would mean is that the payments, instead of being basically -- currently, the payments would be the market basket and then you'd walk back and take out the payment adjustment. And so that would be a net increase of one-tenth of 1 percent, which you are pointing out. If this recommendation were put into place, basically, they would be getting a zero and then the negative 2.75 would be going into place, and that would pull down their rates by --

DR. CROSSON: So this is actually a reduction of 2.9, not 0.15.

MR. CHRISTMAN: That's right. Well, I guess the right way to think about it is, right, they go from getting a positive 0.1 to a negative 2.75. That's what they'd wind up getting.

DR. CROSSON: Thanks.

MR. BUTLER: I want to understand a little thinking on the 5 percent. I understood you were saying had you been paid under the previous system, 20 percent fewer

less payment under the per visit. But why 5 percent? Why not 3 percent? Why not 7 percent? Why not 2 percent or were you just throwing a number out there to test it?

DR. MARK MILLER: That's what we were doing.

MR. BUTLER: If so, I think what could I support? It would be good to have a methodology around it, other than just to say it's too profitable.

DR. MARK MILLER: The number is -- there were some comments made the last time we went through home health and we ended up at zero and people were saying why not start thinking about it. The reduction in the visits, about 30, the reductions in the payment, if you follow this methodology through, was about 20; is that what you were saying? Frankly, we were just coming back off of that to have a conversation to gauge your guys' view of whether there was enough here to proceed.

MR. EBELER: In truth, if you go back to last year, it wasn't a staff number. I put it on the table for two reasons. One is it strikes me that at some point we need to be able to look at some of these systems and not think of zero as the absolute lowest one can go. And second, to the extent that there was a rationale for that

particular number, as we looked at things last year, one could do that and still have an average margin of about 10 points. But you're right, there was no statistic underneath it.

So I put it out there because I do think it is important, as we look at this, not to tie ourselves into this range of zero to three and a half. And if things are really, really going great for you, you get zero. If things are falling off the table for you, you get three and a half. It just strikes me that we need to be willing to have a more sophisticated set of payment adjustments. So it was my number, but I do think we need to talk.

DR. CROSSON: Glenn, can I just follow up then? I just want to make sure. So this recommendation is actually for minus 2.85 or 2.9. The second recommendation is for minus 5 or is it for minus 7.9?

MR. CHRISTMAN: I was afraid people would pick up on this point.

[Laughter.]

MR. CHRISTMAN: Again, I hope we have laid this out, but are just adjusting the market basket and Jay's pointing out that there's two payment adjustments in effect;

one is this negative 2.75, which CMS did under its administrative discretion authority. Our recommendation -- we're assuming those reductions are in place. And our recommendation simply pertains to the market basket. And the market basket, I guess one way to think about it, sets the peg that that 2.75 leaps off of. So if you have a zero update, as as we kind of pointed out, you will go from having a one-tenth of 1 percent update to a negative 2.75 update. I think, as Jay is pointing out, if you have a negative 5-percent reduction to the base rate, then the 2.75 is going to come in on top of that. And so it would be a little deeper than just 5 percent.

But, ultimately, I think as others have pointed out, the 5 percent, that amount is sort of -- it is up to the Commission's judgment if it chooses to go that way.

DR. MARK MILLER: Also, to cast it the other way, do I understand correctly that the margin and the margin forecast assumes these changes? So, also, when you look at their current profitability, this is being assumed, right?

MR. CHRISTMAN: Yes.

DR. MARK MILLER: So I wanted to make that -- there's two ways to look at it. You are right, but also all

of our estimates assume, in terms of their profitability, are taking it out as well.

MR. HACKBARTH: Evan, the coding adjustment is actually for coding change that has occurred over a long period of time. We are reaching deep into the past. So in a way Medicare is trying to recoup dollars that it overpaid going back how many years?

MR. CHRISTMAN: Going back to the beginning of PPS.

DR. CROSSON: The point is, conflating these two conceptually is maybe not the right thing.

MR. HACKBARTH: I think you need to have your mind divided into two parts. One is certainly the net impact is what you've been describing, and that's the way people will portray it on the Hill. What they are talking about is minus 5, and then on top of that another minus 2-point whatever. But, in fact, conceptually, they are quite different things and, for our purposes, it is probably good to think of them as very different activities.

DR. KANE: If you go back to page 7. So the dip, is this a slide just a little misleading in that, well, I'm not sure -- there's a change in eligibility criteria that's

around the same time where they lost a million patients right around ‘97, ‘98, ‘99, somewhere in that, because they changed eligibility. Is that correct? Somewhere in there they had a big tightening up of eligibility.

MR. CHRISTMAN: I don't think there was a significant change to eligibility, as I recall. I believe the big change was they stopped coverage for you could not get home health solely for the purpose of blood draws. But the big change was that they just curtailed payments significantly. And because they curtailed payments, fewer agencies were providing services.

DR. KANE: I know in the write up you say, it says the home health benefit in the early ‘90s began to look like long-term care.

MR. CHRISTMAN: I'm sorry. I thought you were talking about the late ‘90s period.

DR. KANE: Well, I do want to understand kind of when that happened.

MR. CHRISTMAN: In the late ‘80s and the early ‘90s, CMS tried to put -- in the mid ‘80s, CMS tried to put a bunch of administrative limits on the amount of services a beneficiary could get. Those were subsequently overturned

by court action. And so in the early ‘90s, you saw a big growth that was related to an expansion of services because of that liberalization. The other factors, too, you can see the number of agencies were rising significantly in that period, and there were also concerns about just the fraud and abuse. There were people throwing around error rates from that era of 20 and 30 percent in terms of inappropriate services. So that takes you up to about 1995-1996. And those concerns drove to be BBA to include a number of positions that brought down, as you can see in ‘97, ‘98, and ‘99, brought down services and agencies significantly, and that continued basically until PPS was solidly in place.

Under PPS, basically from about 2001 on, you can see that payments and the number of agencies have gone up.

DR. KANE: As of '98 or so, when this episode got defined, which it looks like they’re kind of right in the middle of getting rid of a lot of agencies and people, already those benefit restrictions had been in place for a while?

MR. CHRISTMAN: They really went into place in October of 1997, and what was in place between ‘97 and October of 2000 was a series of sort of cost-based limits

that said, for a given agency, I'm only going to pay so much and for per beneficiary limits. I forget all of the formulas, but they were sort of based on regional and national averages. But there wasn't an episodic payment system that paid on a bundle of services until PPS went into effect. It was kind of like you were still under the cost-based system, but there were also these interim payment system caps that were overlaid on top of it, so it wasn't like a pure TEFRA system.

DR. KANE: I have one other question, and then I will make a comment later. But when you talk about capital costs and access to capital, what are the big capital needs of a home health agency?

MR. CHRISTMAN: In general, for the smaller and midsize ones, to the extent that I'm familiar with them, they are things like cash flow. People want credit for short term. In terms of infrastructure costs, there are IT costs. A lot of home health agencies do run point of care IT systems because of the elaborate assessment required. It's quite common for nurses to have laptops with all of the connectivity you would expect with it. But in terms of the major capital costs that we hear about are people who want

to borrow to acquire new agencies. That is the one that gets the most attention from the publicly traded companies. So that's why, to do the larger deals, they will want to access to the capital markets.

DR. MARK MILLER: I was a little unclear on how the exchange settled out. I was always under the impression that a couple of things that happened at the ‘98-‘99 was that is when the interim payment system went into effect and had a big impact on payments. And another thing, wasn't Operation Restore Trust going on in that same period?

MR. CHRISTMAN: It started in '96, yes.

DR. MARK MILLER: The exchange that I'm trying to clarify here is whether that was an eligibility change or a change from the payment system.

MR. CHRISTMAN: I don't believe it was an eligibility change.

DR. MARK MILLER: And that's the point that I don't think was clear in the exchange between the two of you. I think this is more a function of the changes in the payment system and some of the chilling in the environment generally due to the oversight from fraud and abuse.

DR. KANE: [off mic] So a million people stopped -

- so the number of beneficiaries fell by millions between '97 and 2000 because of a change in payment?

DR. SCANLON: Before '97, home health was going up 25 percent a year, and it was very highly concentrated in certain geographic areas -- California, Texas, Louisiana and Florida. And when the interim payment system, the one feature of it that was particularly troublesome was that they used a cap on your revenues, it was equal either to your own experience in I think 2000, or no, 1994 or the national average.

Well, those areas with high geographic concentration, where the growth was concentrated, they were way above the national average. So all these new agencies suddenly were facing a cap that was so far below what they were doing. They went out of business. In Texas, we had the number of agencies cut in half overnight. And so that's a part of it. That's where you lose so many people just because they had all come in recently and they were gone quickly. Because in part it had become this long-term care benefit.

We had this very small fraction of the beneficiary users that were driving the cost because they were getting

more than 150 visits, largely aide visits.

DR. KANE: So the last thing I want to do, just to tie all these questions, is go to number 19. And 98, then, I'm guessing is still clearing out some of these people?

MR. CHRISTMAN: Oh, definitely, yes.

DR. KANE: So the main drop is in home health aid. So what it looks like to me, from what I'm hearing from this, is that nature of what a home health visit was changed dramatically from being fairly custodial in nature to being much more of a post-acute rehabilitation. And yet we have an episode payment that's based on an old custodial model; is that correct?

MR. CHRISTMAN: I think the way to answer that is, yes, when they set up this payment system, they told them to use the recent data. And they had some assumptions about how much that episode was going to change. There were some adjustments made for them. But the magnitude of those changes was much greater than anybody anticipated.

So the bottom line is, when they set the base rate, they were not using parameters that looked like the benefit that's getting delivered today.

MR. GEORGE MILLER: To be more specific, to follow

up on where Nancy, I think, was going, but let me see if I could put a clarifying question and I'll come back and make a comment. Can you take the data in the three states that you feel that there is fraud and abuse and extrapolate it to what you think may be nationwide?

MR. CHRISTMAN: I don't know. I guess I don't know what you mean. I don't think there is a comprehensive measure of sort of how much fraud is occurring in those three areas, if I'm following your question correctly.

MR. GEORGE MILLER: Back when Nancy was talking about the depth, much of that was fraud and abuse back in '98, '99 that really changed. Anecdotally, we hear stories of cab drivers having home care businesses and all types of things. It seems to me if this is a pattern again then, quite frankly, I would support, and maybe I should go over that when we get to the other recommendations, of much higher. Because if there is fraud and abuse in the system, it's taking money out of the system, and we should make very strong recommendations. If the industry doesn't take care of itself, we should, very strongly.

DR. CHERNEW: I also had a question following up on what Nancy was asking about this chart that is up here

now. Is there any case-mix adjustment in this at all? And, in general, what's your sense of case-mix adjustment in this area, just in general?

MR. CHRISTMAN: Well, I think that the base rate is set based on the mix of services that are in there, and to the degree that there are sort of two changes going on, that, in some sense, if you see mix of services as level of service as sort of a proxy for some measure of severity, this chart is showing you two kinds. One, there has been a drop in the total number of visits, but if you look at the mix of visits, you have got more of the high-cost visits now. So when I talked about the drop in visits, I said that it dropped 30 percent. When I said that the base rate was set using the parameters today, the base rate would only be 20 percent lower. The reason that the base rate doesn't drop as much as the drop in visits, it is because the cost per visit has gone up because we have relatively more physical therapy now and relatively less home health aid.

DR. CHERNEW: I guess I'm trying to separate case-mix inferred by the set of services delivered and case-mix inferred by something about the patient ex ante because there is this new -- the reason I'm asking is because

there's this new payment system coming in and there is this concern about how you deal with these short stays, and stinting and those things. And So in thinking about that, it's just very interesting to me to think through how case-mix might adjust this in the new 153 group -- how well we can think of that case-mix as doing the job and how well we can't.

MR. CHRISTMAN: Home health is unique in that we pay for it in a 60-day bundle. Part of the reason we do that is because people have not found reliable patient characteristics that predict length of stay.

So we're paying for it in these 60-day bundles, essentially. In terms of the accuracy of the case-mix itself, I think many analysts would agree that the home health case-mix has one of the more impressive challenges because of the diversity of the patient group. This is a population where we take people from virtually every setting where Medicare serves someone. They come from the hospital, they come from the community, they come from other post-acute care settings. So they do have a case-mix. We feel like their new system is an improvement. There is still a fair amount of variation within case-mix groups. I don't

know that people would consider it the strongest case-mix adjuster, but I think that's, in many ways, a testament to sort of the challenges of dealing with this population.

DR. MILSTEIN: Listening to this, I am having resonance with our discussion on how to handle our quantified estimate of perhaps overpayment for physician imaging services. And as that discussion emerged, there were two different concepts -- I'm getting to a question. One was the concept of making up for unintended overpayments in one fell swoop. The second concept was not only doing that but also, after you've done that, beginning to gear to what an efficient provider might require.

In this category of care, you don't have the same challenges in defining efficiency as you might in some other categories, where you have very long tales that involve a lot of other providers. It's not pure, but it's less vulnerable to that problem.

So my question is, I just want to make sure I understand, by how much the negative adjustment would be if we wanted to, taking into account the change in mix, account for historical overpayment that we now, in retrospect, believe occurred. That's question one.

Question two is by how much would the negative adjustment be, order of magnitude, if we wanted to gear this to what a so-called efficient provider was delivering? It is to help bracket this discussion because I think all of us intuitively -- I won't speak for anybody else -- but I think there is something, there is concern about pulling a number arbitrarily out of the air. And so if we could have some brackets, some framework for knowing how much the negative adjustment might be geared to certain conceptual notions; i.e., make up for historical -- offset historical overpayment and/or geared to efficient provider requirement, it would at least help me kind of anchor my thinking. So you don't have to, not within a tenth of a percent, but order of magnitude could you help me understand what those would be?

DR. MARK MILLER: To answer that, if you are trying to just talk about numbers here, the first one is the minus 20 thereabouts, if you were just thinking sort of a first cut at what the episode -- if you just followed this visit and the shift in the mix of visits just straight out.

The second point I wanted to drive a little bit, Evan, is there is a process now where adjustments for past

overpayments are kind of working their way through, right?

MR. CHRISTMAN: If you're referring to case-mix related ones.

DR. MARK MILLER: Yes.

MR. CHRISTMAN: Yes, that's coursing its way through the system.

DR. MARK MILLER: And it's not happening all in one year.

MR. CHRISTMAN: Right, it's spread out over four years.

DR. MARK MILLER: What was the estimate, the total on that?

MR. CHRISTMAN: It's basically 11.5 points.

DR. MARK MILLER: So there's a number, just a number.

DR. MILSTEIN: [off mic] [inaudible]

MR. CHRISTMAN: I think Arnie's question, I guess the way I was hearing it, was a little different because the coding mix adjustment we were talking about was for payments related to overpayments for patient severity. I think the simplest way I could think of to put Arnie's question is, if I had a clean sheet of paper and I was pricing the 60-day

episode today, how much lower would that base rate be compared to the one I got? I think the number -- it's still the same number. It would be somewhere between the 16 percent margin I've got for him and that 20 percent base rate number. If I were just repricing the 60-day episode today, with 22 visits, that mix you see up there, it would be 15 to 20 percent lower.

Now, the next question you had was sort of taking that as the average provider, what happened if I priced the episode based on the efficient provider. I'm afraid the only way I can answer that question is more. It would be lower. But by how much? We haven't really done any of that work identifying efficient providers in this area. There is, like we said, a lot of difference in the agencies and the population and some issues to think through there to make sure you are risk adjusting properly, but we see agencies that do much better than 16 percent.

MS. HANSEN: One of the questions I had that may tie into, Arnie, your question, I was thinking about, since this is a 60-day episode payment; is that correct? One of the other measures that we tend to look at is the rehospitalization rate within 30 days, right?

So if we took a look at the home health agencies that had high quality of care, and that is lower rehospitalization, would that be somewhat of a proxy of better quality?

MR. HACKBARTH: So look at the costs of that subset of agencies, in particular.

MR. CHRISTMAN: Yes, we could definitely take a look at that. We do have some work underway in this area, but we haven't broken it out in quite that way. But that's definitely on our list in terms of identifying what the cost differences are for agencies that do do well on the quality measures we collect.

DR. STUART: I agree with Arnie. I think it would be nice to have a number to hang onto, and I think there is a number, actually. If you go to page 12, which describes the base rate reduction that CMS has recommended, one thing we could do is to simply speed up the reduction. In other words, just take that 2.71 percent that is recommended for 2011 and push it up to 2010. Then you've got the rationale for that is what CMS's analysis has already shown. You don't get the 5 percent, but then I think we all agree that 5 percent is somewhat arbitrary, but you're going to get a

negative recommendation.

MR. HACKBARTH: But, again, to go back to the earlier exchange here, that's really about something different. Those are reductions aimed at recouping past overpayments that were attributable to case-mix, as opposed to identifying the level for efficient providers going forward, two separate questions.

DR. STUART: No, I agree. But I don't think we're at a point to base these recommendations on efficient providers. We haven't done it for any of the other -- so I'm just saying, if the sense of the Commission is that these agencies are being overpaid and really we're searching for a recommendation or a handle on trying to not continue to overpay them as much as we are, then this is one mechanism that we might consider.

MR. HACKBARTH: I understand what you're saying.

DR. REISCHAUER: They're baked in the cake already.

MR. HACKBARTH: A budget baseline.

DR. REISCHAUER: Yes, and so all we're doing is getting one year -- the 2.7 one, one year early.

MR. HACKBARTH: Yes. You'd get the acceleration,

yes.

Let me kick off round two by introducing sort of another perspective on this. As bill has pointed out many times over the years, our core problems or one of the core problems with home health payment is the weak definition of the product that we're buying. And I think I'm quoting you accurately, Bill, but correct me if I'm not. I remember you saying last year or one year that you could cut the rates by 10 percent or 15 percent and still have 15 percent average margins because the product would change. They would just offer fewer visits, and some damage could happen in that process.

On the table where you showed the range of margins, Evan, I forgot what page number it was, there is a significant range of the margins. And I think it's true, correct me if I'm wrong, Evan -- well, that’s right, it's on here. The not-for-profit is lower than the for profit. I think even there may be some differentiation within the not-for-profit category. There are some agencies that are different in terms of the target population they're serving. They are serving an unusually difficult target population, and none of that is picked up in our product definition or

our case-mix adjustments.

Bill has suggested an alternative path that we may want to think some about, which I think is appropriate when you've got a weak product definition, which is to say you could have a blended rate; whereby, we pay some on a prospectively determined basis but blend that with a piece it's based on their actual costs, their actual delivery of services, which would have the effect of attenuating the effects at the ends of the distribution. So you'd be taking disproportionately more money out of high-profit organizations, while cushioning the impact on the agencies at the low end of the profit distribution. That won't be perfect. There will be some who are unjustly treated in that, but in the absence of a real strong product definition, across-the-board cuts may be an even riskier approach than a blended rate approach.

Bill, do you want to talk about it?

DR. SCANLON: No, You've been accurate in terms of describing what I've said before. I think today, though, we've surfaced the second problem with respect to home health payment, which is, unlike the other prospective payment systems, where we used to start off with at least a

product or a service and we weren't changing dramatically its nature when we designed the system. We used data from the past and we designed the payment system. With home health, we had this experience where we created a new product in the early ‘90s and then had data from that product experience, and then we started to design a prospective payment system for essentially a completely different product but used that old data.

And the problem we have today, in terms of these average margins, is reflective of that. It's shown in the table which illustrates the reduction in the numbers of visits. So that's one of the problems.

The other problem is the one that’s in this chart here, which is this wide distribution. With this ill-defined product, there's no way we can really get at sort of this wide distribution which is, I think, totally inappropriate for Medicare to be supporting. People making 50 percent profit on Medicare are not that much more efficient than someone else. They're just not providing a service, the same level of service to the individuals.

I have had repeated sort of anecdotal reports of agencies telling someone Medicare won’t allow us to do that

for you. We know the way the Medicare specifications are. They don't say what you can't sort of do. They tell you that you're covering the episode. So there is an issue that agencies are saying we're not going to do that. So there's this question of how do we sort of get Medicare to both pay more prudently for what they're purchasing and to sort of make sure that beneficiaries get what Medicare is paying for.

I think in terms of doing this blending, we have to think about sort of exactly how to structure it because you don't want to take away the incentives that a prospective payment creates for efficiency. You don't want to make it so that person is in a situation saying I don't really care about whether I'm controlling my costs, either when they're on the loss site or on the plus side. You really want to keep some of those incentives in place. So maybe you mute them sone so that you get away from this wide distribution, but you still keep some of them in place. How to do this blend is sort of an open question.

MR. HACKBARTH: We are running behind, and I'd like to move on after maybe say 10 minutes of discussion max. Let me see a show of hands of people who would like to

make some further comments.

DR. CHERNEW: I need a two-minute light. The first thing I would like to say is I'm not yet convinced that I know how much health we get for these low-margin agencies that provide more visits. So I'm not sure how much we're benefitting, one way or another. Although maybe we are getting a lot, I just don't know.

The second question I have very much relates to this, which is I'm torn again between if we think there's overpayment, which is I think what motivates the 5 percent number, it's not clear to me whether the right solution is to lower the base by 5 percent or some other arbitrary number and that brings everything down or to refine selected points in the distribution of case-mix and lower them, so we keep the people in the severest groups the same and we lower the lowest severity groups.

Since we've just moved to this new 153 category bundling system, I guess I would like to know why the right way to solve any overpayment is to move the entire 153 payment rates down as opposed to targeting the areas where we think they're not being particularly efficient or we think that payments are particularly high. I could

understand the arguments either way, it's just not clear to me why we have to confound the overpayment and selected bundled places versus overpayment on average for everything.

MS. BEHROOZI: I'm glad you talked about the wide spread in the margins because I was comparing it to the SNF spread of margins, and this is like a 20-percent greater spread even from the bottom to the top and you don't want to hurt the ones who may be at low margins but doing the right things.

I have not as much faith, as I think a lot of other folks here do, in the ability of a payment system to incent properly the appropriate kinds of care. The proposal to add a per-visit increment to an otherwise reduced or cap on payment system, I'm not sure that that's not going to give the incentive to do more visits just for the sake of getting paid.

So one thing that was in the paper is the notion that there's no requirement that a physician see the home health patient before, during or after. That's even worse than the hospice thing, where at least a physician has to sign a form at the outset. It seems to me that there's some things that we should be requiring, and I know it's not in

the context of the update, but requiring is part of the benefit. And we have talked before about having an expert panel come and give some advice about what the benefits should contain. But sort of a physician taking a look might be one thing.

And then -- Bill has said it before, so I guess I do like it's okay to say it -- the idea of profit caps. In New York State Medicaid, we call it a G&A, a general and admin cap. That's why I was asking before if that's a euphemism for profit. Maybe there's just an excessive level that the taxpayers' money should not be used for.

MR. GEORGE MILLER: Mitra covered one of my concerns about the quality of care and the fact that a position is not involved in the process. I think that's a very strong point, particularly in the delivery of care to make sure there is quality care. Again, I want to come back to the fraud and abuse issue, which may be because there is not a physician involved in the certification process. I'm not sure of the answer, but I'm extraordinarily concerned. I was in Texas, and I remember the fraud and abuse days back in the '90s. For example, I was in a town called Jasper, Texas, that a population of 10,000, and we had 34 home care

businesses in a town of 10,000 people. So we knew there was fraud and abuse. I'm concerned that this is repeating itself because of the way the payment system is. I'm not sure of the solution to it. Again, I'll say this very boldly, if the industry doesn't take care of itself, then maybe we should. And that will send a lesson because these margins are just ungodly, quite frankly.

DR. MILSTEIN: In our reports and in our statements we aspire to coming up with a payment system that stimulates innovation among providers such that they're constantly seeking ways of getting better outcomes with less health insurance fuel, right? That's what we are after here.

In most provider categories, we don't have a prayer of getting there because we don't have great outcomes measures. And frankly, we also tend not to have enough slush in the base rates to really move an amount of money into quality-based payment to really light a fire under provider innovation.

I see this as one fantastic opportunity in one sector for us to test our rhetoric.

What I would point to is I think we do know the

product we want to buy. It is in slide number nine. It's called functional capability, which is the end goal of this product, right? is increases in this.

So here we have a payment category where, unlike almost all others, we have a pretty good set of outcome measures. We have, secondly, evidence of a lot of slush in the base pay rates.

So I put this together and say it is a terrific opportunity for us to test our theory of stimulating innovation, and I come out strongly in favor of recommendation number two, but perhaps with maybe a more aerobic version of recommendation number two, in which we essentially say instead of a minus 5, it's minus 15 because that's what we think the right answer is based on, as I heard Evan's answer. But that amount of money goes into the quality-based payment system and the quality-based payment system is geared to the health outcomes we are after, which in this one category of service we have a much better dashboard for than almost any other category.

So I favor recommendation two but with perhaps an amped-up version.

MR. HACKBARTH: My recollection, Evan, is that

when we talk about pay for performance for home health, there was some concern about these measures and how the data are collected. You have people going out there making subjective assessments of these things, and it was one of the reasons, not the only one, but one of the reasons we were interested in looking at things that were more objectively determined outcomes like readmission to the hospital and discharge to the community. Scratch that, that's a different sector. But more objectively determined measures of performance than these. Did I remember that correctly?

MR. CHRISTMAN: I think there was some concern about them. I think the word was sort of people were thinking they might be more comfortable with process measures or things that weren't as -- I think the challenge, though, is that I think Arnie is right in that these measures went through the, excuse me, the National Quality Forum vetting process and so forth, in the sense that the community feels that this is what home health, in many cases, is trying to accomplish. And so they feel like, in a sense, we struggle for outcomes in other settings.

One of the other concerns Commissioners have

mentioned is the difficulty is that these outcome measures are self-reported, the agency collects them. That's a difficult one to address. Virtually every piece of information we collect in the Medicare program is self-reported. This information is not unique in that regard.

MR. HACKBARTH: Although some things are more subject to audit the other things.

Let me go on. I have Nancy and then Jack and then we're going to have to move ahead.

DR. KANE: I may not be understanding something, but it seems to me that it’s not an update issue. It's how they set the payment and what data set they're using. I'm not quite sure why they are using ‘98 to set payment levels. I am assuming -- is that still the data set because we don’t have visit data?

MR. CHRISTMAN: The parameters for this are pretty prescribed in law. They said you will use the experience from -- I'm not going to get the language exactly right -- but you are going to set it using 1994 data; with certain adjustments, ‘98.

DR. KANE: And it's still there.

MR. CHRISTMAN: Yes. The bottom line is CMS today could not just rebase these payments.

DR. KANE: So, obviously, we might want to talk to Congress. But to me, to use '98 data, which is the wrong population and wrong product, to set payment rates for a different population doesn't make any sense to me at all. Why don't recommend, rather than a percentage, just say Congress should change this to 2007 visits mix and use the payment -- and change the payments to be based on 2007, rather than 1998. And then we'll find out where it lands, and I'm guessing it will land 15 percent below. But why try to pick a number, when actually the data could allow you to it in a much more -- and then instead of setting them through the update factor, which I think is the wrong place to be doing this, we have a fundamentally flawed way of setting payment that we could fix by simply changing the date to reflect the product we have been buying more recently and then say update whenever.

MR. HACKBARTH: So it would be a recommendation to rebase the home health rates.

DR. KANE: Yes.

MR. HACKBARTH: Jack, you get the last word.

MR. EBELER: I think that's a helpful comment, but we'd need to stress that we're not suggesting a budget-neutral rebasing, we're suggesting a rebasing. I think the quality discussion is helpful as well. As Glenn knows, I do think contemplating this idea of a blended rate in an area like this may be a valuable part of that as well because it is a squishy thing to get our arms around.

MR. HACKBARTH: Okay, lots of food for thought and further discussion there. I wish we had more time to do it right now, but we don't. Thank you, Evan.

So we have two more sessions left today, and we were running about 25 minutes behind schedule for those who are keeping score.

MR. HACKBARTH: Next up is inpatient rehab facilities. Kim, are you going to lead the way?

MS. NEUMAN: Yes, good afternoon.

The next section we're going to look at is inpatient rehab facilities, or IRFs. I'm going to present the most recent data on IRFs for your consideration as you assess Medicare payment adequacy for these providers.

But before I do that, I'll briefly recap a few background points about IRFs.

IRFs provide intensive rehabilitation services. The Medicare fee-for-service program spent about $6 billion on IRFs in 2007. Medicare fee-for-service beneficiaries account for over 60 percent of IRF patients.

In 2002, a prospective payment system for IRFs was implemented. Prior to that, IRFs were paid based on cost.

Because IRFs are generally regarded as providing more intensive costly services, there are criteria that Medicare has established to determine whether a beneficiary qualifies for IRF services and whether a facility will be paid as an IRF. A Medicare beneficiary must generally be able to tolerate and benefit from three hours of therapy per day in order to receive Medicare covered IRF services.

Facilities must meet several criteria in order to receive payments as an IRF. The criteria are shown on the slide. The criterion that has received the most attention in recent years has been the 75 percent rule.

You've heard about the 75 percent rule in past meetings. I'll recap it briefly, since the data I will present later shows the effects of this rule on IRF patient volume and case-mix.

The 75 percent rule, originally established in

1983, required that 75 percent of a facility's patients have certain diagnoses in order for the facility to be paid by Medicare as an IRF. The rule was suspended temporarily in 2002 when CMS found that many IRFs were not in compliance. In 2004, the rule was reinstated with some changes.

First, they established a policy that limited the types of hip and knee replacement patients that count toward the 75 percent rule.

Second, they established a phase-in of the compliance threshold over several years beginning in 2004. The phase-in timeline is shown on the slide.

In December 2007, the Medicare, Medicaid, and SCHIP Extension Act capped the compliance threshold permanently at 60 percent, retroactive to July 2007 and going forward. For ease of reference, I'm going to continue to refer to this rule as the 75 percent rule during this presentation, since for most of the period our data covers providers were under the impression that the threshold was being phased in to eventually reach 75 percent.

Next, we'll look at the most recent data on IRFs in the various areas of the update framework. First, supply of facilities. The top line in the table shows the trend in

the total number of IRFs. After implementation of the prospective payment system in 2002, the total number of IRFs increased modestly at an average annual rate of about 1.2 percent per year from 2002 to 2005. Since then, the total number of IRFs has decreased at a similarly modest pace, declining on average 1.2 percent per year from 2005 to 2007.

Next, we have data on another aspect of supply, the number of beds. The number of beds increased after implementation of the PPS from 2002 to 2004 and has decreased modestly from 2004 to 2007 at a rate of about 1.2 percent per year.

In the next slide that I will show you, you will see that the volume of IRF admissions has decreased, as well from 2004 to 2007. It's notable that the decline in the number of beds has been slower than the decline in the number of IRF admissions, suggesting that service capacity remains strong.

Next, we have data on trends in Medicare fee-for-service volume and payments. There was a substantial increase in Medicare fee-for-service volume and spending from 2002 to 2004 following implementation of the PPS. Volume decreased from 2004 to 2007, coinciding with

the phase-in of the 75 percent rule.

Some of the decline in IRF fee-for-service volume in total spending in recent years is a result of increased Medicare managed care enrollment. The top two lines in the table are largely unaffected by changes in managed care enrollment, so we'll focus on those.

Looking at the first line of the table, it shows the volume of IRF services as measured by the number of Medicare fee-for-service IRF patients per 10,000 fee-for-service beneficiaries. We see that volume increased from 2002 to 2004 at an average rate of 4.4 percent per year. Volume decreased from 2004 to 2007 at an average rate of 7.5 percent per year.

While not shown in the table, the decline in volume appears to have slowed somewhat in 2007. Underlying that 7.5 percent average annual decrease in volume from 2004 to 2007 is a decrease of roughly 9 percent per year from 2004 to 2006 and a decrease of 5 percent in 2007.

While volume has declined, payments per case have increased substantially, as shown in the second line of the table.

The next chart shows the change in composition of

the IRF Medicare patient population between 2004 and 2008. In 2004, major joint replacements of the hip and knee were the most common IRF diagnosis, comprising 24 percent of cases. Since then the number of hip and knee replacement cases have declined, representing only 13 percent of cases in 2008.

Stroke has become the most common IRF diagnosis for Medicare patients, followed by hip fracture as of 2008. Again, these shifts are consistent with IRFs' adjustment to the 75 percent rule, particularly the criteria put in place in 2004 limiting the types of hip and knee replacement patients that would qualify for Medicare covered IRF services.

The decline in the number of IRF cases has raised the question of whether the 75 percent rule is creating an access problem. To look at this issue, we've tracked how the patterns of discharges from hospitals to post-acute care settings has changed over time. This slide focuses on the example of hip and knee replacement patients. As you'll recall, you've seen this data before in last year's work. We have updated it with the most recent year's data.

Since 2004, the share of hip and knee replacement

patients that are discharged from hospitals to IRFs has decreased while the share discharged to home health and SNFs has increased. While the data do not tell us whether outcomes have been affected, the data suggest that hip and knee patients previously treated in IRFs are receiving care in other post-acute care settings.

On the outcomes front, there is some work underway by CMS that may shed light on this issue. In the post-acute care demonstration project mandated by the Deficit Reduction Act, CMS is fielding a common patient assessment instrument across post-acute care settings which may provide information that can help us look at differences in outcomes across settings. A report to Congress is due in 2011.

Also of note is that CMS is required to submit a report to Congress on the impact on the 75 percent rule on access to care in the summer of 2009.

Moving now to assessing the quality of care, we use a commonly tracked measure by the IRF industry, the functional independence measure, or FIM. The FIM score measures physical and cognitive functioning with a higher score meaning greater functional independence.

To measure quality, we look at the average

increase in the FIM score between admission and discharge, commonly referred to as FIM gain. We look at this for all beneficiaries in IRFs and beneficiaries discharged home. We'll focus on the all beneficiary data, since the general trends are similar for both groups.

Looking at the data for all Medicare patients, we see in the third line of the chart that FIM gain between admission and discharge has increased from about 22 in 2004 to about 24 in 2008. This suggests that quality may be increasing but we need to be cautious in drawing conclusions because the data are not risk adjusted to reflect changes in case-mix over time. In the future, we intend to pursue risk-adjusted methods for measuring quality trends for IRFs.

Now turning to access to capital, as with other sectors discussed today the economy-wide credit crisis may impact IRFs access to capital. 80 percent of IRFs are hospital-based and receive access to capital through their parent institution. Thus, the issues discussed earlier today concerning hospitals' access to capital, such as increased cost and delayed capital investment, would carry over to hospital-based IRFs.

Similarly, freestanding IRFs may face access to

capital issues due to the economy-wide credit situation. These changes in the credit markets are broad and not related to changes in Medicare payment policy for IRFs.

Now moving on to payments and costs, as you can see in the slide payment and cost growth tracked each other closely prior to the PPS. Since implementation of the PPS in 2002, overall aggregate payments have grown faster than costs. Between 2004 and 2006 costs per patient accelerated, growing at about 10 percent per year. This reflects, in part, changes in IRF admissions patterns, as IRFs admitted fewer lower complexity patients that don't meet the 75 percent rule. And also it may reflect the overall decline in discharges and the resulting impact on economies of scale.

Between 2006 and 2007 growth in costs per case has slowed somewhat, to about 5.5 percent.

The next slide shows the trend in IRF Medicare margins over time. IRF margins increased markedly with the implementation of the prospective payment system. Medicare margins peaked in 2003 at about 18 percent and have declined somewhat since then but still remain strong. In 2007 the aggregate IRF Medicare margins is 11.7 percent, down 0.6

percent from the prior fiscal year.

The next slide shows the breakdown of IRF margins by different categories of providers. There is substantial variation in IRF margins across providers with the margin at the 25th percentile being negative 5.7 percent and at the 75th percentile being 19.2 percent.

Freestanding and for-profit IRFs have the highest profit margins, 18.5 percent and 16.9 percent respectively. Hospital-based IRFs and nonprofit IRFs have margins of roughly 8 to 9 percent. Urban IRfs have somewhat higher margins than rural IRFs, about 12 percent versus 9 percent. As you will recall, rural IRFs receive a 20 percent payment increase due to their rural status.

We have modeled margins for 2009 using 2010 payment policy except for the update. We project a margin of 4.5 percent in fiscal year 2009. This is a protected decrease from the 11.7 percent margin we estimate for fiscal year 2007. The decrease is driven almost entirely by the zero update between 2007 and 2009 mandated by the Medicare Medicaid and SCHIP Extension Act of 2007.

To summarize, facilities and beds declined modestly in 2007. Volume and total spending declined in

2007 while payments per case increased. Access to care appears to be a adequate but is complicated to assess. For quality, there's been an increase in functional gain over time but case-mix changes prevent definitive conclusions. The 2009 projected margin is 4.5 percent.

To start your discussion, we have the Chairman's draft recommendation, which is the same as last year's recommendation. The draft recommendation reads: the update to the payment rates for inpatient rehabilitation facilities should be eliminated for fiscal year 2010.

The implications if this draft recommendation were adopted in fiscal year 2010 are in terms of spending, a decrease in spending relative to current law. Current law would be market basket. In terms of beneficiaries and providers, overall we would not expect a substantial impact on beneficiaries' access to care or providers willingness to further services to Medicare beneficiaries. There may, however, be increased financial pressure on some providers.

Overall, we would not expect a substantial impact on beneficiaries' access to care or providers' willingness to furnish services to Medicare beneficiaries. There may, however, be increased financial pressure on some providers.

It is possible this could lead some providers, such as those with very small numbers of discharges or those that have not restructured their costs in response to recent changes in admissions patterns, to evaluate their IRF operations, especially if there are other more profitable uses for the space.

That said, we would not expect a widespread impact on providers' willingness to furnish inpatient rehabilitation services and we would not expect a substantial impact on beneficiary access to care, as in recent years IRF occupancy rates have been in the 60 percent range, suggesting that additional capacity is available among existing IRF providers and possibly other post-acute care settings.

With that, I will conclude the presentation and look forward to your discussion.

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

Can I see hands for first-round clarifying questions?

MR. BUTLER: I'm just trying to understand again, you're projecting a 4.5 percent margin for 2009; correct? And the margins on that -- so you're going all the way back

to 2007 are the most recent margins that you have on the previous slide. If you could flip back to that, which is slide 15, you don't have any idea of where there are going to fall by category? The 4.5 is the aggregate estimate for the --

MS. NEUMAN: It is. It is the aggregate estimate. We make the projections at the aggregate level because it's harder to make projections at individual category levels.

DR. MARK MILLER: Generally in forecasting -- and this is true in all of the 2009 margin numbers that we've put up -- since we made kind of general assumptions, actually tracking it back through categories of either types of providers or types of services gets more sketchy.

MS. HANSEN: This is probably more of a request for previous charts for the next time we look at this. Just as we were intrigued with the distribution of services on dialysis, I think we've had charts before just arraying the geography of these locations, as well as not only for this but then I guess for the next segment in the future, the LTCHs, as well. Just so that we get a sense of the distribution, as well.

MS. NEUMAN: I can definitely add that.

MR. EBELER: Could you flip chart 10 up there. Just to say a little bit more about -- there is a variety of providers that we deal with who, for some post-hospital patients, provide similar services. Could you just sort of say whether there are -- whether we think there are clinical distinctions among patients who are going to the IRF versus home health or SNF or even long-term care? Or is it who happens to be there? How do we sort among these providers?

MS. NEUMAN: That's a really interesting question and there's not necessarily a definitive answer. What I can tell you is that one of the criteria for a hip and knee replacement patient, which is what is in this chart, to count toward the 75 percent rule is that they have certain characteristics that make them more likely to need intensive services.

So if it's a bilateral joint replacement, if they're frail, over 85, or if they have a very high body mass index. So in sort of the 75 percent rule, there is some targeting of these patients toward IRF versus other settings.

That said, we don't have a common patient assessment instrument across settings, so it is, to some

extent, difficult to be able to give definitive answers about the difference in characteristics of patients across these settings.

MR. EBELER: And we do pay differently in the different settings for what could be the same patient; right?

MS. NEUMAN: Yes, we do pay differently.

MR. HACKBARTH: Is there a map that has distribution of IRFs? I don't recall one in the package.

MS. NEUMAN: No, there's not. We will add that.

MR. HACKBARTH: Are they as geographically concentrated as some of the other post-acute providers like long-term care hospitals, the particular pockets around the country?

MS. NEUMAN: They are more evenly spread out. There is definitely variation. But as of 2006 there was an IRF in every state and they seem to be -- the ratio of the number of IRFs to fee-for-service beneficiaries varies within a more reasonable range.

MR. HACKBARTH: To some extent, I assume these patterns are affected by availability of IRFs. And where IRFs don't exist, skilled nursing facilities may look

different and have different capabilities than in communities where there are IRFs. So the providers adapt to what exists in that community.

MS. NEUMAN: Yes.

MR. LISK: One other thing, just to mention for this slide, to also take into consideration, is that with hip and knee replacements, there have also been technology changes and stuff that have changed the patterns of care about what is done with hip and knee replacements from earlier time periods. More people are likely to go home now than in prior periods.

DR. KANE: Slide 13, is there something in the drinking water or something around the early 2000 period, when they switched to all these post-acute payment systems? Then suddenly people start seeing differences between payment and cost like that? Because that's true also in the other --

MR. LISK: Yes, it is.

DR. KANE: What happened in that period that allowed the prospective payment systems to be so dramatically apart and above cost? It almost looks like the payment system is dragging up the cost.

DR. REISCHAUER: [off mic] [inaudible]

MR. LISK: You could wonder about that. The initial reaction -- I think you'll see it also in long-term care hospitals -- is the first year actually they held their cost growth almost to zero. But payments when up. When they saw payments went up, costs ended up going up after that, as they had more revenues to spend, it seems is the pattern that has happened.

MR. HACKBARTH: And there are issues about case-mix change, that these case-mix systems are put in and there's some creep in the case-mix and creep in the payments and costs, in many cases, follow to some degree especially in the not-for-profit institutions.

I think there are a variety of different things that contribute to this picture, which as you say is not unique to IRFs.

MS. HANSEN: This is more of a question that's broader, as we've talked about use of these different locations, perhaps for the same condition. Do we have any information on the managed-care plans and how they use post-acute services, as compared to kind of a standard fee-for-service approach? Or is that even a relevant way to

think about this?

MS. NEUMAN: That's something, actually, they we're very interested in looking into more. What I can tell you is that GAO did a little bit of looking at this. And what they found is that some of the commercial payers will do sort of a preauthorization approach for IRFs and look very closely at the individual to decide whether or not they're appropriate and sort of do it on a more case-by-case basis. So what we like to do is to look more at what the commercial payers are doing to get a better understanding of different approaches.

MR. HACKBARTH: It may be useful, just to refresh my recollection along with other Commissioners about the journey that we've been on with these post-acute providers. We've often, over the years, observed that to some degree at least they're substitutes for one another. Clearly, it's in the Medicare program's interest to make sure that people get the least intensive service possible consistent with a good outcome.

We don't have, unfortunately, the tools that allow us to do that assessment. We don't have common assessment tools. Patients aren't always assessed at admission and

discharge. We don't know how they change over time.

We've got some infrastructure issues that need to be addressed in the broad post-acute area. We've made some recommendations for that, and Congress has asked CMS to do some work on development of common assessment instruments and the like.

Can you say anything, Kim, about where that work stands?

MS. NEUMAN: Sure. There's the Post-Acute Care Demonstration Project, which is fielding a common patient assessment instrument across the various post-acute care settings. They started fielding at demonstration sites early this year. The report to Congress, however, won't be available until 2011. So there will be some time before we see the output of that. But it's definitely a promising step forward.

MR. HACKBARTH: All right. Let's go to round two. Any further comments or questions on IRFs?

MR. BUTLER: I think I can support the recommendation. But this is one of those, it's like Jack previously. There's something in between maybe a market -- there's something that is a little bit of an increase but

not a market basket minus productivity that -- I'm a little concerned about the downward trajectory on this and where it's going to land. And I do think that this is one that, at least on the hospital side, has worked pretty well.

If you look at the last couple of years, the 60 and 75 might have been arbitrary. But it did succeed in getting the joint replacements out of the units and that wasn't the cheapest best place to do them. So I think we've had some success in that. And now we're filled -- as the chart very well describes, stroke and other things that are needed.

Again, I kind of look at it like this morning, too, and the portfolio of hospital-sponsored kinds of things which shows the aggregate margin. So you support zero here, then that offsets some of the market basket, the full market basket that was this morning. So it decreases the overall profitability.

So I'm trying to look at the whole portfolio at the same time.

So what am I recommending? So I think zero is a reasonable proposition. I'd like to know a little bit more if there's any way to understand the split though between

what has gone to the freestanding that was up at 18 percent and the hospital side was at 7.9 percent, and whether again there is a mix issue that we're just missing on this. If there was a way to address that than I would say sure, zero maybe is the right number.

DR. CHERNEW: Related to this mix issue, I have the same sort of feeling in all of this. And that is so if I understand the way that the reasoning basically works, the margins look pretty healthy, the access seems reasonable, the quality seems reasonable. So that leads us to an assumption that's sort of at the low end of the set of assumptions that we tend to use. That's at least my read of how this went.

My question again relates to how much that is we just want to lower everything on average, versus maybe there's some overpaid and underpaid case-mix groups. Because there is this variation in the margin.

So if I understand correctly again, margins are always done at the IRF level or more broadly at the facility level. So you don't have a margin for person, you have a margin for IRF. I never thought I'd say that.

[Laughter.]

DR. CHERNEW: But you could look to see if there's variation in margin associated with various case mixes. So the profitable ones are all getting some of the case-mix groups and the non profitable ones are getting others, to see if this high margin is sort of a problem and everything is sort of inflated, or it's a problem that some popular case-mix groups are overpaid. And that would make a difference to me in how I thought about it.

But an absence of that, and I'm assuming you're not going to do that any time soon, I think the recommendation is reasonable.

MS. NEUMAN: Just to comment on that, in the long-run I think we can look at the case-mix issue that you're mentioning.

DR. REISCHAUER: Going to Jack's point, it strikes me that before you know what to do about an update you have to have a positive answer to one of three questions. Do they provide a unique service or for a unique group of people? Do they provide non-unique services better than the competitive institutions? Or do they do this cheaper than other people? And until you know that the answer to one of those questions is yes, you don't whether this is an

institution worth preserving, in a sense.

And to get to that point, I was wondering if we know anything -- most of these things are in hospitals and we ring our hair about SNFs declining in the hospital sector. And you wonder, are these a substitute for the SNFs that are, in a sense, doing what the hospital-based SNF did best? And can we look at whether there are hospitals with both of these or they are substitutable for each other or what? Just to get some kind of feel for what is this that's going on?

MR. LISK: I haven't looked at that recently, in terms of that. I did look at kind of the relationship between if a hospital had a hospital-based SNF and an IRF. And generally they had one or other and not both. There are some hospitals that had both. But generally they have potentially one or the other if they have them.

And there are some hospital-based SNFs that may have converted over to being IRFs.

DR. REISCHAUER: That's why I wanted to know whether if you look at longitudinally, you would find the SNFs disappearing and these things appearing because the profitability of one exceeded that of the other.

MR. HACKBARTH: To go to your initial set of questions, it's hard to answer them definitively. But my sense has been yes, there is a group of patients that need this especially intensive care. The patients that have been treated are broader than that group that really needs and benefits from it.

The 75 percent rule was an effort, albeit a somewhat crude one, to try to get them focused on the patients that uniquely need it. That effort, combined also with the zero update, has helped to bring down the margins substantially from the double digit level down to the projected 4.5 percent, was it?

And so I think we're sort of moving on a path towards refocusing these institutions. Whether we're there or not I really don't know. I suspect probably not. So that would be my off-the-cuff assessment of how to answer your questions.

DR. REISCHAUER: It's sort of interesting that the hospital-based SNFs have the horrendously negative margins and these guys don't.

MR. HACKBARTH: Right.

We're on round two questions.

MR. GEORGE MILLER: First, I'd like to reiterate Peter's point and then I want to follow up Bob's statement with a question.

But as we look at these, today we've looked at these issues, particularly those that are hospital-based, as silos. I think Peter's point bears repeating, that if we agree to no updates that adversely affects the hospitals because those margins are already in the number. I just wanted to say that again.

But Bob brought up a question and I wonder if we've done research. Did we know what the impact of mostly on IRFs and maybe even SNFs on states that had CON versus states that did not have CONs? And if there's a correlation or a pattern or some impact?

MS. NEUMAN: We haven't looked at that but we can take a look.

MR. GEORGE MILLER: I'm just wondering if it has an impact on payments, the growth or lack of growth because of a CON in a state.

MR. HACKBARTH: Let's see, anybody else for round two?

Before we close this session, does anybody else

want to specifically address the draft recommendation? In particular, anybody who's opposed to it. Who wants to speak?

Okay, thank you very much, Kim and Craig.

Last, but not least, long-term care hospitals.

MS. KELLEY: This session will address the payment adequacy for long-term care hospitals. We follow the same Commissioner framework that you're very familiar with at this point.

I'll start with a little bit of background to refresh your memory about LTCHs. Patients with clinically complex problems who need hospital level care for relatively extended periods are sometimes treated in LTCHs. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay of greater than 25 days for its Medicare patients.

Due to these long stays and the level of care provided, care in LTCHs is expensive. Medicare is the predominant payer for this care.

Since October 2002, Medicare has paid LTCHs under a per discharge PPS. Rates are based primarily on patients'

diagnosis and the facility's wage index. Additional payments are made for cases with extraordinarily high costs. Payments are also adjusted for short stay cases. Roughly a third of cases are affected by this policy.

In addition, under the 25 percent rule, hospitals within hospitals and satellite LTCHs receive reduced payments for cases admitted from their host hospitals after they exceed a threshold.

Following implementation of the PPS, Medicare payments for LTCH services grew rapidly, climbing an average of 29 percent per year between 2003 and 2005. Between 2005 and 2007, however, growth in spending slowed dramatically with spending in 2007 virtually the same as in 2005, $4.5 billion. CMS estimates that total Medicare spending for LTCHs will be $4.6 billion in 2009 and will reach $5.8 billion in 2013.

Here's a map for Jennie. As you can see, LTCHs are distributed very unevenly. Some areas have many and others have none. The five states with the greatest number of LTCH beds together account for 38 percent of available beds but only 11 percent of the Medicare beneficiary population.

The triangles on this map show the facilities that entered the Medicare program prior to October 2003. The circles represent LTCHs that entered the program after that date. As you can see, a fair number of circles overlay triangles, indicating that newer LTCHs frequently have located in markets where LTCHs already existed instead of opening in new markets. This is somewhat surprising because these facilities are presumed to be serving unusually sick patients and one would expect these patients would be relatively rare. The clustering of LTCHs and the location of new facilities has raised questions about the role that these facilities play in the continuum of care.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 made some important changes to Medicare payment policy for LTCH services. Beginning in 2008, the law places a moratorium on new beds and facilities for three years. The law also makes changes to the 25 percent rule.

As I mentioned, the 25 rule sets a threshold of Medicare patients who can be admitted from the host hospital of a hospital within hospital or satellite LTCH. After the threshold is met, payments are reduced.

MMSEA rolled this threshold back to 50 percent

until 2011. MMSEA also prevents CMS from applying the 25 percent rule to freestanding LTCHs until 2011.

In addition, MMSEA made changes to the short stay outlier policy. Beginning in July 2007, CMS reduced payments further for cases with the very shortest stays. Many of these cases were to be paid at acute care hospital rates but MMSEA prohibits CMS from applying this very short stay outlier policy, again for three years, until 2011. These changes to the 25 percent rule and the very short stay outlier policy are expected to increase total payments to LTCHs.

Turning now to our update framework. Our first consideration is access to care. We have no direct indicators of beneficiaries' access to LTCH services but assessment of access would be difficult regardless because there are no criteria for LTCH patients and because it's not clear whether the patients treated in LTCHs require that level of care.

To gauge access to services, we look at the number of facilities available and the number of services used. After a long period of rapid growth, the increase in the number of LTCHs participating in the Medicare program has

leveled off. As the green line shows, from 1990 to 2005, the number of LTCHs quadrupled from 97 to 388, climbing an average of 11.3 percent per year. Between 2005 and 2007, however, there was a net increase of just eight LTCHs. The yellow and blue lines show that for several years hospitals within hospitals were growing at a faster rate than freestanding LTCHs, about 16 percent annually from 2002 to 2005, compared with an average of about 5 percent for freestanding.

Between 2005 and 2007, the total number of hospitals within hospitals fell while the number of freestanding facilities continued to grow. This turnaround is likely due to the 25 percent rule, which was expected to have this kind of an effect.

We also looked at the number of LTCH beds. Nationwide there were approximately 26,500 Medicare certified LTCH beds in 2007. As I mentioned, these are distributed very unevenly.

The number of LTCH cases grew an average of 10 percent per year between 2003 and 2005. Between 2005 and 2007, the number of cases fell by 2 percent. This decrease can be explained by a decline in the number of

fee-for-service beneficiaries resulting from growth in Medicare Advantage. This suggests to us that access to care was maintained during the period.

Turning to quality, we look at several measures that can be calculated from routinely collected administrative data and which give us a gross indication of quality. In this sector, we are a little bit behind other sectors in terms of collecting quality data.

We looked at the share of patients who died in the LTCH, the share who died within 30 days of discharge, and the share who were readmitted to the acute care hospital for each of the top 15 LTCH diagnoses. These diagnoses account for 60 percent of all LTCH patients.

We found that readmission rates have been stable or declining for virtually all of these diagnoses. Rates of death in the LTCH and death within 30 days of discharge also have been declining for most diagnosis. Where death rates have risen, in all but one case type the number of admissions has declined as well, sometimes markedly, which could indicate an increase in the severity of illness within the diagnosis group.

The sole exception is septicemia where we see a

large increase in admissions and a relatively large increase in death rates, both in the LTCH and within 30 days.

We also look at hospital level patient safety indicators that were developed by AHRQ and we will be presenting that information in January.

As discussed in other presentations today, the current economy-wide credit crisis means that LTCHs access to capital probably tells us little about Medicare payment adequacy this year. In 2008, most businesses within the health care sector and without faced higher capital costs and have less access to capital in general.

Tightened credit will affect LTCHs as it will all businesses, but the impact will likely vary across the industry. Financial analysts are expecting accelerated earnings growth for the largest LTCH chain, Kindred, a publicly traded company which provides most of the information we have about the industry. This positive forecast is due to improved Medicare reimbursement after passage of MMSEA, growth at newly opened facilities and the use of new high acuity SNF beds co-located in LTChs. On the other hand, analysts report that the outlook is less positive for some smaller LTCH chains that continue to be

highly leveraged.

Still, it's important to remember that more than half of all LTCHs are co-located within an acute care hospital and so may have access to capital through that connection. And of course, the three-year moratorium on new beds and facilities imposed by MMSEA limits opportunities for expansion and therefore reduces the need for capital.

How have LTCHs' per case payments compared to per case produce costs? Under TEFRA, a cost-based payment system, payments and costs tracked each other fairly closely. This, of course, is a similar chart to what we just saw in the IRF presentation. Per case payment and cost growth was relatively low under TEFRA and actually declined in 1999 and 2000. Under the PPS, payments have increased significantly, and as payments have gone up so have costs.

In 2003, 2004, and 2005 payments grew much faster than costs. Much of the growth in payments was due to increases in reported case-mix of the patients going to LTCHs. CMS expected that coding under the new classification system would improve. They've made adjustments accordingly in their payment adjustment in the updates that they've given to LTCHs over the past several

years.

Improvements in documentation and coding can be expected to decline over time as LTCHs become more familiar with the classification system. This may have help dampen the most recent growth in payments per case where you see the gap between payments and costs beginning to narrow in 2006. Of course, now we have refinements to the case-mix system that went into place just recently, so that may cause some more gyrations in this area.

Consistent with this pattern of payment and cost growth, margins for LTCHs rose rapidly after the implementation of the PPS, rising from a bit below zero under TEFRA to a peak of 12 percent in 2005. In 2007, the average margin is 4.7 percent.

This slide shows the Medicare margins for different LTCH groups. As you can see, there's widespread in the margins, similar to what we've seen in other settings with a quarter of hospitals have margins of negative 5.2 percent or less and another quarter having margins that are 13.1 percent or more in 2007.

Historically, margins for hospitals within hospitals tended to be slightly higher than those for

freestanding institutions but in 2007 that has flipped. Margins for for-profit LTCHs are quite high compared with those for not-for-profits.

For purposes of projecting 2009 margins, we modeled a number of policy changes. These include the effects of updates and changes to the high cost outlier fixed lost amount, as well as changes to the short stay outlier policy wrought by MMSEA. Since MMSEA also rolled back the 25 percent rule generally to the level it was at in fiscal year 2007, our model assumes that providers' response to the 25 percent rule going forward was the same as it was that year.

As you can see here, we project both increases and decreases in payment but the basic message is that LTCH costs have grown faster than payment updates received in rate years 2008 and 2009. We project a net decrease in payments in 2008 and a net increase in payments in 2009. Overall, assuming providers' costs go up at market basket levels, we have projected a margin of 0.5 percent in 2009.

Our margin estimate assumes no behavioral response to changes in the 25 percent rule that have been implemented from 2007 to 2009. If the industry responds to these

payment changes by restraining their costs, the margins would likely be higher than what you see here.

To sum up, we see growth and use has stabilized in this industry in 2007 after a period of rapid growth. Our quality findings are generally positive. I'm sorry, this is a misprint on this slide. The quality findings are generally positive, not mixed. Although we are still waiting to see the results of our analysis of the patient safety indicators.

Access to capital varies across the industry but in the current economic environment is not a reliable indicator of Medicare payment adequacy.

In the absence of changes in provider behavior, increased payments in 2009 are not expected to outpace growth in cost. Finally, we've estimated margins for 2009 at 0.5 percent.

Last year the Commission made the following update recommendation for LTCHs and the Chairman is going to use this as a starting point for your discussion today. The recommendation reads the Secretary should update payment rates for long-term care hospitals for rate year 2010 by the projected rate of increase in the rehabilitation,

psychiatric, and long-term care hospital market basket index less the Commission's adjustment for productivity growth.

The Secretary has discretion to update payment rates but CMS has stated its intention to use the market basket as a starting part for establishing updates to LTCHs. This, a recommendation of market basket minus productivity will produce savings relative to a market basket update.

For beneficiary and provider implications, over time reduced margins may result in fewer LTCHs participating in Medicare. Given the availability of other types of providers, it's unclear whether this poses a problem for access to beneficiaries.

We'll be happy to answer any questions you have and look forward to your discussion.

MR. HACKBARTH: Dana, how is the budget baseline determined when the Secretary has discretion on the update?

MS. KELLEY: That's a good question.

DR. MARK MILLER: I thought in our conversations -- and don't take this for a fact -- is that CBO is generally assuming a market basket.

MS. KELLEY: That's what I thought, too, but I...

MR. HACKBARTH: Thank you.

Could I see hands for a first round of clarifying questions?

DR. STUART: Thank you very much.

This is another one of those trying to figure out what we're actually getting. But in this particular case it looks like the extreme uneven geographic distribution might offer a natural experiment. And I'm wondering whether you have attempted, in some way, to determine whether people who had the same characteristics of those that were treated in these long-term care hospitals but were in an area in which the hospitals didn't exist and how they were treated and what their costs patterns were.

MS. KELLEY: We looked at this issue in 2000 -- it was using 2001 data, I believe -- and published the results in our 2004 report. What we were able to look at was the use of a total episode of care for patients who used LTCHs versus those who did not. And we tried to control for case-mix as best we could.

The result was that we found that patients that used LTCHs generally typically had higher episode costs. But for patients, for the particularly sickest patients, particularly those, for instance, ventilator patients, the

difference between patients that used LTCHs and patients that did not narrowed considerably.

I don't know if that -- RTI, under contract to CMS, has also done some work on this issue.

One thing that we do not know is how outcomes compare. We don't have very good measures of outcomes. Unfortunately, my understanding is that the PAC demo is not going to help us much with this because the PAC demo is only going to be looking at patients that use post-acute care. So for instance, we'd be able to see what patients look like if they went to a LTCH versus to a SNF but we won't be able to see what patients who go to an LTCH look like compared to patients who stayed in the hospital longer, for example, unless they go on to post-acute care.

DR. STUART: Do you have plans to redo this analysis in the current years?

MS. KELLEY: It's certainly something we could do.

DR. MARK MILLER: But we didn't have plans.

[Laughter.]

DR. STUART: I didn't mean that as a criticism.

DR. MARK MILLER: And it wasn't taken that way. I wanted just to be as straight as possible.

What happened is when we did that analysis, which we did a few years ago, it set off a chain of events where we were pushing the industry and CMS and the Congress to change the payment system so they would set criteria on patients so that it was focused on the high severity level four, vent, et cetera, patients where we actually found there might be a role here for this level of care.

That process is kind of churning along, and then also this issue became much more urgent of we don't really understand when we look across these post-acute care settings -- and there were other things driving it -- which drove this demonstration. So we sort of set some things in motion.

And to be direct, no, we had not planned to come back and look at this. But as Dana said, we could.

MS. KELLEY: As I said, RTI has done this a little more recently under contract to CMS. And CMS's request for this work was directly related to the work that we had done previously. The MMSEA required a report from CMS on the development of criteria for LTCHs and that report is due in June of this coming year.

MR. LISK: They presented some of their stuff on

the LTCHs at the Academy of Health meeting that I attended, and consistent with some of the earlier stuff we found is some of the most intensive patients they found actually were more cost effectively treated in the LTCHs but some of the less intensive may not have been and more mixed. So it's kind of a mixed picture.

But we can get back to you more specifically with what they had.

MR. BERTKO: Bruce asked the first half of my question. The second half, Craig, might come from the presentation you went to, which was in Montana and Oregon there are no LTCHs whatsoever. Does that RTI work tell you what the differences in payment levels by some state that's obviously substituted something else for LTCHs?

MR. LISK: A lot of what is substituted for these real severe cases are hospital outliers. So you're talking about extreme hospital outliers. That's actually one of the more comparison groups. And I think their study did try to address that in terms of getting at hospital outliers, which we hadn't gotten at before.

MR. BERTKO: Is that something we could know at the next meeting?

MS. KELLEY: Their results from RTI? Sure. That's something we could bring to you for sure, a summary of that.

The other thing, this makes me think of a question we had last year about how managed care organizations use these services. My recollection is that generally they don't very often. There was some managed care organizations that I talked to for very specific patients where very specialized LTCH care was available -- again the ventilator -- the failure to wean in the hospital patient came up in that discussion.

But generally what I was told is that managed care organizations typically find that if patients can stay a little bit longer in the hospital, if they can get the hospital to keep them longer, that then they often are able to go to a SNF.

DR. KANE: My question was around managed -- whether we have any information from the MA plans on their use of all four really post-acute types of services compared to fee-for-service?

My understanding is weren't we going to ask for at least encounter data? And are we asking for it in the

post-acute sector, as well? Weren't we trying to get data on utilization differences between MA and fee-for-service? Is it also including post-acute or just...

MS. KELLEY: This came up last time. Carlos, the encounter data?

MR. HACKBARTH: CMS has taken the initial step towards requiring the data. What detail is included, I don't know.

DR. MARK MILLER: [off mic] Carlos, it should include the encounter data for this, as well.

MR. ZARABOZO: [off mic] I thought it was a rhetorical question.

[Laughter.]

DR. MARK MILLER: Carlos, we talked about this. You're not supposed to do that in these meetings.

[Laughter.]

DR. MARK MILLER: We will go back to the Agency and try and get a sense how this -- they said something in regulation. We have not been able to nail down what the timeline is. But this has come up repeatedly. This point is well taken. Bruce, you've brought this up, as well. If we aren't getting a sense of urgency and things rolling out,

this may be something as a group we want to make a statement about because this comes up time and time again.

MR. GEORGE MILLER: Thank you. Dana, I think you said that some of the LTCHs within the hospital may have access to capital. And that's not an issue?

MS. KELLEY: What I said was that a little more than about half of the facilities are hospitals within hospitals and those facilities may have access to capital through their parent organization.

It's also true that some of the hospitals within hospitals are owned by other companies.

MR. GEORGE MILLER: That's correct. That was my follow-up question.

MS. KELLEY: That would be a more complex relationship.

MR. GEORGE MILLER: So do you know that number? That's my follow-up question.

MS. KELLEY: I don't know the exact number and I can try to pin that down a little bit for you next time. I will say that -- why don't I pin it down next time, rather than misspeak?

MR. GEORGE MILLER: That then would change your

statement of it's a larger --

MS. KELLEY: The second largest LTCH chain predominantly has hospitals within hospitals, as opposed to freestanding facilities. So it is a significant number of them, yes.

MR. GEORGE MILLER: Thank you.

MR. HACKBARTH: Let's move on to round two, and the draft recommendation is up there. I would, in particular, like comments on that, and in particular reservations about the draft recommendation if you have any.

MR. BUTLER: Let me start with the punchline, I can support the recommendation as stated.

Let me make some very brief other comments. I think that unlike the blurring between home health and skilled nursing and some of these, I think these units can -- particularly for ventilator treatment -- it's kind of like the only place. They do a very compassionate, often excellent job, in a way that no other setting does if they really focus on particularly those patients. And they can do it reasonably cost effectively, I think.

The second point is I think some have made comments that payment goes up, costs goes up. If we just

drop payment, costs will go down, as if that's a simple equation. I don't think this is an area where if you have the payment go down, you have -- it's not simple to reduce the cost. I think that's true for a lot of areas but in this, in particular.

So my message would be that unlike home care, where you can enter and exit the market fairly quickly without a lot of capital, this one may be one if we -- we monitor it quickly. So we don't want to tip it over and lose the whole thing and throw out the baby with the bath water.

MR. HACKBARTH: Other comments on the draft recommendation?

MR. EBELER: Across most provider areas we have a payment for quality component? Do we have that in old recommendations in this area? And if not, why not?

MS. KELLEY: No, because we don't have very good quality data in general in this area.

MR. HACKBARTH: Others? Again, in particular I'm eager to hear about concerns. But if you want to say something positive, I also like that.

MR. EBELER: I meant to say I support the

recommendation.

MS. HANSEN: It's positive, but it actually goes back to a question about -- again maybe I should've asked it in the last round. When treatments do change, and an example of use of any of these facilities, not just the LTCH but going back earlier, if the standard of practice is changed and an example might be the way hip reductions are done, that it's more done in microsurgery as compared to others, is there any way that we can adjust in the way we look at the cost of post care impact on that?

Because what has happened is the method has changed. I think we talked about this a little bit earlier but whether it's cardiac areas, stuff related to hips, those things are changing as we go. And as a result, we're not measuring apples to apples.

MS. KELLEY: Over time, in looking at the payments and costs by case-mix group, over time presumably we would see that change in the cost. I'm trying to think of what else, I think that's really -- yes. It's a moving target. So presumably as a future case-mix refinement came up it would address that by adjusting costs.

MS. HANSEN: But there's not a faster way to

adjust but you have to wait for kind of a real retrospective to catch up eventually?

MS. KELLEY: Usually.

MS. BEHROOZI: I support the recommendation but in the spirit of trying to figure out how to insert something that we want while we give an update, is there some kind of data reporting that we could insert a requirement for that would get some more of that quality judgment assessment going?

MS. KELLEY: There is certainly room here for collection of any quality data. We are hopeful that some of the answers to that question will come out of the PAC demo. Again, it is a little further down the road. But that should provide good information about the quality of care in specific LTCHs and quality across different post-acute care settings.

Again, it will not answer the question of how quality and outcomes in an LTCH compare to patients who might have stayed longer in the hospital. So there will be that complicating factor. But the PAC demo should hopefully provide some answers here and ultimately, I think, will lead to the collection of additional data.

DR. MARK MILLER: The other thing is as I recall as we were talking to the industry back and forth about our initial set of recommendations, trying to get the criteria and all of that, there was some discussion of quality metrics. And maybe one thing that we can do is go back to them and start saying so, what are you thinking along these lines?

And since Dana has unlimited amounts of time, and I can actually see some of them sitting in the audience, maybe we could at least go back and try and have that conversation and see if we can start to frame up the kind of places where we might want to focus developing measures.

I remember discussions of things about rates of weaning people.

MS. KELLEY: Much of the industry does in-house collect these data and there is going to be -- there is a couple of industry groups getting together to look at outcomes and effectiveness a little more systematically. So there might be some information that comes out of that as well.

MR. HACKBARTH: Any others?

Everybody look at your watches. It's exactly

5:15, which was the scheduled time to finish, which I think signifies that you exactly measured the point of exhaustion.

Thank you, Dana. Thank you, Craig.

Okay, we'll now conclude today's session with our public comment period.

Let me just take a minute to remind you of the ground rules. Please begin by identifying yourself and your organization, and limit your comments to no more than two minutes. Your two minutes are up when this red light comes back on.

I would also remind people, if there are others who plan to make the same comment, it really suffices if you say I agree with points A, B, and C made by the preceding speaker, as opposed to restating them over and over again.

MS. ZELLER: Thank you, Mr. Chairman. My name is Carolyn Zeller. I'm with the American Medical Rehabilitation Providers Association, complete with a cold.

I wouldn't say it was providential that there was zero update and that the lights went out, but I would suggest it was a comment on the recommendation.

We are concerned because, as you may know, the volume -- we have data through 2008 showing the volume has

not recovered with the change to the 60 percent rule. We think this is for two reasons. Most people went to 65 percent, and there's considerable fear about Medicare necessity denials continuing and the RAC program coming in, resulting in a continued cost per unit that we see that may be having an effect on the margins going forward that you can't see from the data at this point.

Number two would be we've had the frozen market update, which was represented in the presentation. And we think another one will put us really quite a ways down. We will give you some further data on that point.

With those two points, we will be sending you a letter because my cough drop is not working. Thank you for your time.

MR. HACKBARTH: Okay, thank you very much and we start the public session tomorrow at 10:00 a.m. For Commissioners, we have our breakfast meeting at 8:30.

[Whereupon at 5:18 p.m. the meeting was recessed, to reconvene at 10:00 a.m. on Friday, December 5, 2008.]

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 5, 2008
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
JACK C. EBELER, M.P.A., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
FRANCIS J. CROSSON, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
ROBERT D. REISCHAUER, Ph.D.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. We have two sessions today, one on Medicare Advantage, one on Part D, and we're going to start with Medicare Advantage.

DR. HARRISON: Good morning. Carlos and I will present new information on the Medicare Advantage Program today, and we will present findings that will go into our March Report chapter.

More specifically, I will present the latest data on plan enrollment--the availability of payment plans for 2009, and our analysis of bids and payments for 2009. Carlos will present data on benefit enhancements and go over our previous recommendations.

Let's start with enrollment. Enrollment in MA plans continue to grow substantially in 2008. From November 2007 to November 2008, enrollment in MA plans grew by 16 percent or 1.4 million enrollees. There are now just short of 10 million beneficiaries enrolled in MA plans, comprising 22 percent on all Medicare beneficiaries.

Enrollment patterns still differ between urban and rural areas. Plan enrollment grew about 30 percent in rural areas and about 15 percent in urban areas. However, despite

the strong growth in rural areas, about 13 percent of rural beneficiaries are in MA plans, while in urban counties, about 25 percent of Medicare beneficiaries are in plans.

If we look across types of plans we see growth in all plan types. Private fee-for-service plans add at 600,000 enrollees, the greatest number of any plan type, and now there are about 2.3 million private fee-for-service enrollees. I do want to point out, however. That the rate of growth for private fee-for-service has been slowing considerably. The 35 percent growth figure this year, though robust, was much higher the last few years and both local and regional PPO enrollment grew faster than private fee-for-service this best year.

Meanwhile, HMOs added 400,000 releases this year, and now enroll 15 percent of all Medicare beneficiaries.

Now, let's look at plan availability. Access to MA plans remains high in 2009, and Medicare beneficiaries will have a large number of plans to choose from. MA plans are available to all beneficiaries, as has been the case since 2006.

More local Coordinated care plans will be available in 2009 than in previous years. 88 percent of

Medicare beneficiaries will have a local HMO or PPO operating in their county, up from 85 percent in 2008, and 67 percent back in 2005.

I don't have all of the historical data to produce separate rows for HMOs and local PPOs, but for 2009, 82 percent of beneficiaries will have an HMO available, and 68 percent will have a local PPO available.

Access to regional PPOs increased to 91 percent in 2009, up from 87 percent previously, and this marks the first time that a regional PPO has entered one of the five regions that did not attract one when the regional PPOs were first introduced in 2006.

Now, private fee-for-service plans continue to be available in 100 percent -- to all beneficiaries, but I'd like to remind you here that MIPPA provisions are expected to decrease the availability of non-network private fee-for-service plans beginning in 2011.

The number of plan historic high, and there will be an average of 34 planned choices per county.

A quick reminder again to help get us through the next slide, let me briefly describe how CMS determines payments to plans. A bidding process is combined with

administratively set bidding targets, called benchmarks, to determine the capitated rates paid to plans. Plans submit a bid for the basic Medicare benefit, and it is compared with the benchmark. If the bid is higher than the benchmark, the plan is paid the benchmark, and beneficiaries would pay the difference with a premium.

However, if the bid is below the benchmark, the plan is paid its bid plus 75 percent of the difference between the bid and benchmark, and the remaining 25 percent of the difference is retained by the Medicare program. The plan must then use its share of the difference to enhance its benefits. Carlos will go into more detail on the enhancement in a couple of minutes, but first I'm going to show that, despite a competitive bidding process, high benchmarks have resulted in payments to plans well in excess of the cost Medicare would bear to cover the same beneficiaries in the Medicare fee-for-service program. The benchmarks are above fee-for-service because of some technical factors, but primarily because the Congress wanted to encourage plans to go to low-payment areas, which were often rural areas not served by plans, thus Congress guaranteed that no county would have payment rates below so-

called floor rates. In many areas, the floor rate was well above the county's fee-for-service Medicare cost.

Our analysis of plan benchmarks and MA payment levels show that both continue to be well above fee-for-service spending. We find that, in 2009, MA benchmarks will be, on average, 118 percent of spending in Medicare's traditional fee-for-service program, bids will be 102 percent of fee-for-service spending, and payments will be 114 percent of fee-for-service spending. Both bids and payments are up a point from this past year.

Now, let's focus on a few plan types. We estimate that HMOs bid an average of 98 percent of fee-for-service spending, which suggests that HMOs can provide Parts A and B benefits for less than the cost of fee-for-service in most areas. However, because of the high benchmarks, we are still paying them 113 percent of fee-for-service.

Other plan types bid more. For example, private fee-for-service bid, on average, 113 percent of fee-for-service which, by the way, was an increase of five points from last year. In addition, private fee-for-service plans tend to attract enrollees from floor counties, so their benchmarks average 120 percent of fee-for-service, and as a

result, Medicare payments to private fee-for-service will average 118 percent of fee-for-service.

I also want to call your attention to the employer-only plan line. You may remember that last year we found that employer group plans bid much higher than plans that are open to all beneficiaries. That is still the case, and here you see that they bid 109 percent of fee-for-service, and are paid 115 percent of fee-for-service. What you can't see here is that we've found that employer plans bid higher within each plan type, and a striking example is that HMOs bid 106 percent for the employer-only, while HMOs open to all beneficiaries bid 96 percent of fee-for-service.

And if you want more information on the employer issue, I can give it to you later on in questions.

Now, I want to discuss a technical issue. CMS updates Medicare Advantage county-level benchmarks annually. Each county benchmarks is increased from its previous level by the greater of 2 percent or a national growth percentage. However, in so-called rebasing years, benchmarks are raised to 100 percent of the county per capita fee-for-service spending if the county's benchmark would otherwise be lower.

By law, CMS must update the estimates of county

fee-for-service spending at least every three years, but may update more frequently if it chooses.

Rebasing goes only in one direction: It can only increase benchmarks. This can be a problem if the rebasing occurs due to an anomalous estimate because of a one-time event.

An anomalous estimate could result for two reasons: First, there may be a spike in fee-for-service spending in one year that is not representative of the long-term trend for the county. The reasons for an unusually high spending year could range from a particularly severe flu epidemic, to random year-to-year variations, which is an especially common occurrence in counties with small numbers of beneficiaries.

Second, the estimate could be based on spending that includes fraudulent claims, and I want to alert you to a troublesome example that is occurring this year. Miami-Dade County's benchmark increase for 2009 is 13 percent. Miami received this increase because its fee-for-service spending for 2009 was projected to rise from previous levels based on the spending patterns in Miami over the past few years. Those spending patters, however, included hundreds

of millions of dollars in payments for claims that have since been proven fraudulent. The 2009 increase in the benchmark means that plans enrolling Miami beneficiaries will receive between $150 million and $200 million more in MA payments in 2009 than they would have if the benchmark had increased at the national growth rate. And once a county is rebased up, the county keeps its higher benchmark, no matter how much subsequent fee-for-service spending declines.

And I want to turn it over to Carlos.

MR. ZARABOZO: As Scott mentioned, when a Medicare Advantage plan bid is below the benchmarks, 75 percent of the difference is to be used to enhance the benefit package for plan enrollees.

Listed on this chart are the five options that plans have for benefit enhancement. A plan can choose one or more of these options. The majority of dollars that go towards benefit enhancement are used to reduce cost-sharing for coverage services under Medicare Part A and Part B. This comprises 60 percent of the dollars, which is a proportion shown in red on the pie chart.

The next category, adding benefits not covered by

Medicare, comprises 21 percent of the dollars, and the three remaining options, reducing the Part B premium, reducing the Part D premium, or enhancing the Part D benefit comprise the remaining uses of the dollars available for the enhancement of the benefit when the bid is below the benchmark.

Using the data that Scott has shown you, here we are including information about the level of enhanced benefits in relation to fee-for-service expenditures. Across all plan types, the bid for the Medicare Part A and Part B benefit package is, as Scott showed you, 2 percent above Medicare fee-for-service expenditure levels. That's the 102 percent figure in the third column that is labeled bids with load.

The term load refers to the fact that the planned bids for covering the Medicare A and B benefit package include loading factors for planned administrative costs, in providing the benefit, and a loading factor for the planned margin.

As shown in the second row, bids by HMO plans, including their administrative costs in margin, are at 98 percent of fee-for-service, or 2 percent less than fee-for-service. All other plan types have bids for the Medicare A

and B benefit package that exceed fee-for-service, as shown in the third column, bids with load.

For example, local PPOs shown in the third row had bids that are at 108 percent of Medicare fee-for-service expenditure levels.

While only HMO plans have bids below fee-for-service, for all plan types, the bids are, on average, below benchmark levels. That is, the first column of numbers, the benchmark, is always higher than the second set of numbers, the bid. So, plans are paid the bid for providing the Medicare Part A and Part B benefit, and in addition, they receive a payment to provide enhanced benefits, because they are all bidding below the benchmark.

On average, across all plan types, the total payment, as shown in the fourth column, is 14 percent above fee-for-service, but a portion of the payment is for enhanced benefits.

The last two columns show the value of the enhanced benefits. On average, the value of the enhanced benefits is 12 percent of fee-for-service costs, as shown in the next to the last column of numbers.

What we do in the last column is express the value

of the enhanced benefits as a dollar figure. On average, including the load factor for enhanced benefits, across all plan types, the value of the enhanced benefits for 2009 is projected to be $89 per person per month. This is close to the current 2008 level, which, according to CMS, is about $96 per month, or $1,152 per year.

The value of the enhanced benefits varies significantly by plan type. The second row shows that HMOs are providing enhanced benefits valued at $115 per member per month, because they are bidding well below the benchmark level.

As we note in a bullet point at the bottom of the chart, some of the enhanced benefits and HMO plans are financed by the plan's ability to bid below Medicare fee-for-service levels, the 2 percent difference between the bid and Medicare fee-for-service expenditures.

This 2 percent difference, along with the remaining 13 percent that plans get paid above fee-for-service levels allows HMOs to have enhanced benefits valued at $115 per person per month. This means that about 87 percent of the $115 is financed by payments above Medicare fee-for-service expenditure levels. That is, 87 percent of

the cost to the enhanced benefit is borne by the Medicare program in the form of payments above fee-for-service expenditure levels.

As is true for the bids, the level of enhanced benefits varies significantly by plan type, as shown in each row of the table.

For example, comparing HMOs to private fee-for-service plans shown at the bottom, the value of enhanced benefits is almost three times higher for HMOs. Private fee-for-service plans are receiving payments that are 118 percent of fee-for-service, but enhanced benefits are valued at only 6 percent of fee-for-service, or $40 per person per month, including the load for enhanced benefits.

Because private fee-for-service plans have bids that are 13 percent higher than fee-for-service, the benefit enhancement in private fee-for-service is financed entirely by program dollars paid in excess of Medicare fee-for-service expenditure levels.

In this table, we present a different way of looking at the enhanced benefits in terms of what they are costing the program, and the cost to the people who financed the program, that is, taxpayers and Medicare beneficiaries.

The first column is the average monthly dollar amount of payments to plans in excess of Medicare fee-for-service expenditure levels.

The next column, repeated from the preceding table, is the value of the enhanced benefit, which across all plans, again, is projected to be $89 per person per month in 2009.

As I mentioned, the value varies by plan type, with HMOs having about three times the level of benefit enhancements compared to private fee-for-service plans.

The next column is an adjustment to the preceding column, based on an estimate of the load that is associated with the enhanced benefit. That is, the administrative cost and margin associated with the enhanced benefit.

Overall, across all plans, for example, the $89 figure is reduced to $79 when you remove the loading factors. Using this adjusted amount with the load factor removed, what the last column in the table shows is the cost per dollar of enhanced benefit, which is the number in the first column, or $103 for all plans, divided by the next-to-last column, the adjusted value of the enhanced benefit.

The last column shows what the cost is for each

dollar of enhanced benefits in relation to the dollars spent in excess of fee-for-service expenditure levels.

For example, given that across all plans the dollar value of payments above fee-for-service is $103 per enrollee per month, as shown in the second column, if the value of the enhanced benefits was also $103 per enrollee per month, the figure in the last column would be $1. That is, for every dollar spent in excess of fee-for-service, $1 would be going back to beneficiaries in the form of enhanced benefits.

However, because plans are bidding at levels above fee-for-service overall, and some of the money paid to plans in excess of fee-for-service is used to finance the Medicare benefit package in the plans, it costs the program $1.30 per enrollee per month to provide $1 in extra benefits, as shown in the first row of numbers.

In the case of HMOs, shown in the second row, because their bids for the Medicare benefit package are below Medicare fee-for-service expenditure levels, the program spends $0.97 to get $1 in enhanced benefits. The enhanced benefit becomes progressively more expensive to the program as you go down the plan types shown here. For PPOs,

it takes about $2.00 in program payments to finance $1.00 in enhanced benefits.

The very last entry in the table shows that in the case of private fee-for-service plans, on average, the program spends $3.26 per enrollee per month to get $1 in enhanced benefits.

To conclude our presentation, we'll review the Commissions past recommendations on MA issues from the June 2005 Report to the Congress. The first two items shown on this list have been addressed by the Congress. The Commission had recommended the elimination of the stabilization fund for regional plans, which would have provided extra funding to these types of plans under certain circumstances. This recommendation was addressed most recently in the Medicare Improvements for Patients and Providers Act of 2008, or MIPPA.

MIPPA also addressed a second item, the issue of the double payment for Indirect Medical Education on behalf of MA enrollees. Inclusion of IME amounts in the benchmarks will be phased out as a result of MIPPA.

The third item listed is the most significant recommendation, which is that Medicare Advantage benchmarks

should be set at 100 percent of fee-for-service expenditure levels.

In other recommendations that have not yet been addressed, the Commission recommended that there should be a pay-for-performance aspect in payment in MA.

The Commission also had a technical recommendation regarding the bidding process for regional PPOs.

And finally, the Commission recommended that the Secretary calculate measures of quality in the traditional Medicare fee-for-service program that would enable a comparison between fee-for-service and Medicare Advantage.

On this last point, Congress has directed MedPAC to report on the methodology for such a comparison, a provision that was included in MIPPA.

This concludes our presentation, and we look forward to your questions and discussion.

MR. HACKBARTH: Thank you. Could I ask a question about the rebasing process? If you could put up the relevant slide, Scott, that would be helpful. What I understood you to say is that when the rebasing occurs it's based on one year as opposed to a moving average?

DR. HARRISON: No, they still do the moving

average.

MR. HACKBARTH: So that what had been tended to reduce the effect that you focused on of a single bad year due to unusual factors.

DR. HARRISON: That's right. Would reduce it.

MR. HACKBARTH: That was my clarification. Let's do round one clarification questions.

DR. CHERNEW: Just picking up on what Glenn said, I think this -- what I call the ratchet effect that you're talking about, despite the five-year averaging that Glenn talked about, I think substantively is actually more important then people recognize. I haven't actually seen the analysis to say but I just wanted --

DR. HARRISON: I think Dan presented some stuff last month that short of showed how things moved and I know for part of that he is looking at the five-year averages. There are examples counties that their rates are now 50 percent above fee-for-service because at one point there are rates of dire?

DR. CHERNEW: Right. We saw that our data that we worked on in --

DR. HARRISON: Generally those are smaller

counties.

DR. CHERNEW: Right.

DR. HARRISON: Now, the Miami issue this year sort of brings it into light.

DR. CHERNEW: My only point was I think the five-year averaging actually hasn't solved as much of the problem as one might think. But the question I had was when you look at a MA plan type like, say, one of the PPOs that's bidding above the fee-for-service, how much of that, in your estimation, is simply because they are paying higher payment rates than the traditional Medicare -- the traditional Medicare program is getting lower payment rates, and how much of it is in some aspect in utilization, either they're getting a worst-case mix that we're not adjusting for in some way or, this is hard to say, but not managing utilization the way you might think a managed care plan would manage?

DR. HARRISON: Well, until recently we really didn't think there were a lot of payments above fee-for-service to physicians but some areas have looked like that's going on, particularly like Portland, Oregon and we've heard some claims about Minneapolis. And I don't think that there

are big numbers, like it might be in some places like 102. Now, Portland may be different, but I think for most of the country they are not paying well above fee-for-service. Maybe John would know something about that.

MR. BERTKO: I would agree with that completely and, Mike, the part that you haven't added in there of the possible one is also the cost of administering the benefit, which is a portion of the reason why the bid would be above fee-for-service if utilization and payment rates are about the same. So that brings the bid up above fee-for-service.

DR. CHERNEW: So you think that's important a part of why the fact that private fee -- I would just say -- I know this is round one, sorry. The fact that private fee-for-service is so much higher and its private fee-for-service and that's because of administration is surprising to me.

MR. BERTKO: No, it's a combination of three things. So, in private fee-for-service, payment rates, because of the current ability to use deeming are almost always right at the Medicare prospective payment rates. A utilization is frequently a trifle better, they're not Coordinated care plans, but they achieve some goals. And

then there's an administrative cost which, frankly, is bigger than what CMS can administer the fee-for-service benefit for, and then there's margins.

DR. MARK MILLER: And then part of his question was different mix, but all of this is adjusted for mix, right? That's not contributing to the higher bids? I thought he asked a mix of -- he did ask that. So I'm just asking these guys to --

DR. HARRISON: I'm sorry. A mix of what?

DR. MARK MILLER: Patients.

DR. HARRISON: No, that should be accounted for.

MR. GEORGE MILLER: Yes, thank you. On page three, when you show both rural and urban, do you have this broken down also by minority groups enrolled in Medicare Advantage programs? And what percentage --

DR. HARRISON: No, we don't. We have plan level enrollment by County. We don't have individual enrollment.

MR. GEORGE MILLER: So there's no way to differentiate or --

DR. HARRISON: We might have historical data like a few years back where we might be able to get some of that, but no, generally not.

MR. HACKBARTH: So, Scott, when we read in the press of the claims of disproportionate minority enrollment, what is the source of that claim?

DR. HARRISON: I believe they were looking at the ZIP codes.

MR. ZARABOZO: MCBS-based information, also.

MR. HACKBARTH: Actual enrollee by enrollee, they're assuming it based on location.

DR. HARRISON: They may have had some plan data, too.

DR. KANE: On page 11, I have a couple of questions. The first column says dollar amount and payment above fee-for-service. In that fee-for-service calculation, is Medicare's administrative costs --

MR. ZARABOZO: Yes.

DR. KANE: Yeah. And so, then, when you go to the value adjusted for load there's a differential there that's the load, I assume, or the administrative plus profit amount for each plan?

MR. ZARABOZO: Correct. That's the administration margin.

DR. KANE: And that's the entire amount that they

-- so, for the HMO, the difference between value and value adjusted for load is about $12-13?

MR. ZARABOZO: Right.

DR. KANE: That's their entire administrative plus profit load?

MR. ZARABOZO: For the enhanced benefit.

DR. KANE: For the enhanced benefit.

MR. ZARABOZO: Right, which is a slightly different -- for example, if you reduce the Part B premium, there's no load associated with that. That's a straight dollar change.

So, this reflects the distribution of the kinds of enhanced benefits. That's the -- the load's calculation is part of that.

DR. KANE: So the $13 per member per month, then, is only a subset of the administrative plus profit?

MR. ZARABOZO: Yes.

MR. HACKBARTH: Carlos, you're just assuming that the load is the same on the added benefits as on the core with the exception of things like premium.

MR. ZARABOZO: Correct.

DR. KANE: So, there's probably a 13 percent per

member per month on the A and B benefits, as well.

MR. ZARABOZO: Right.

DR. KANE: Do we know what proportion of the load is administrative versus profit?

DR. MARK MILLER: We have some ability. It's kind of -- accuracy is the question. We have some ability to do that. How much we can parse that out and at what levels of aggregation start to raise questions.

DR. KANE: One of the things is there's quite a bit of variability here. So, here $13 down to $5 per member per month of load and --

MR. ZARABOZO: But again, it's percentage. You have to look at the dollars in relation to the numbers.

DR. MARK MILLER: Let me say that differently. Do you assume a constant percentage across plans for doing the enhanced benefit load?

MR. ZARABOZO: No.

DR. MARK MILLER: So there's some variability.

MR. ZARABOZO: Right.

DR. MARK MILLER: I'm going to say this just slightly differently. You use the same load factor and what varies is the mix of enhanced services that are provided by

any given plan type?

MR. ZARABOZO: Yes.

[Laughter.]

DR. MARK MILLER: Permission to treat as hostile.

MR. HACKBARTH: "What's My Line" back in the '50s.

DR. KANE: Does it sound like --

MR. HACKBARTH: Let me add just ask for clarification on that. Does the load vary by plan type?

MR. ZARABOZO: Yes, but we are aggregating. We're dealing with very aggregated numbers, so yes.

MR. HACKBARTH: Yeah. But when you do these calculations, you use the average load for the plan type, apply same load to the enhanced benefits as to the basic benefits.

MR. ZARABOZO: Correct.

MR. HACKBARTH: With the exception of the premium.

MR. ZARABOZO: That's right, the premium reduction on the Part D benefits.

MR. BERTKO: And maybe for Nancy's benefit, I would add that there's a fixed price component of admin. Most of the HMOs are in urban areas with higher payment rates and if it costs you let's say $100 to administer a

benefit, in urban areas it might be on $1,000 base, and in private fee-for-service areas, the average base might be $700. But the $100 fixed cost doesn't vary; it just becomes a higher percentage and is thus partly reflected in some of the indications up on this slide.

MR. HACKBARTH: So, it would also be increased because it's spread over a smaller membership base, on a per-member basis.

MR. BERTKO: It depends on the company, of course.

DR. KANE: I'm just trying -- so, that's the add-on that if it was in fee-for-service we just wouldn't incur? This is all on top of what it takes Medicare to administer this benefit which is already incorporated into the fee-for-service?

MR. ZARABOZO: That's right, yes.

DR. MARK MILLER: Yes, but also, just to be clear -- I think you understand this, but I want to make sure everybody understands. You're talking about the difference between, say, 40 and 35 and saying that there is administrative costs. But also the 40 is an additional benefit on top of fee-for-service in just benefit -- or the 35 is in additional benefits?

DR. KANE: Yes. Medicare doesn't offer that.

DR. MARK MILLER: Got it. Right.

MR. HACKBARTH: I have three more people in the queue: Peter, Jay and Jack, with clarifying questions.

MR. BUTLER: Let me see if I can ask what I think is a complicated question, but there are obviously -- an HMO model does better than the others and I'm a big believer in some of these models, like Kaiser be set up to actually manage care the way you'd like them to manage.

Now, over the last couple of months, my first introduction here in the Commission, we've looked at the regular Medicare program and targeted everything from hospital readmissions, excessive imaging, George's home health programs in Jasper, Texas, utilization issues from various aspects. And the only thing we've looked at in Medicare Advantage is a glimpse at the quality and HEDIS things, but I would be curious, if you were to line up the HMO model there against this laundry list of utilization targets we have in fee-for-service and have some comment on how they are doing. Obviously, the aggregate spending might be reasonable, but do we see significant shifts between the buckets of dollars and those plans versus the traditional

fee-for-service plans?

MR. ZARABOZO: I don't know that we know that right now until we have the encounter data, and let me address the question that arose yesterday about the encounter data.

MR. HACKBARTH: [off mic] The rhetorical question.

MR. ZARABOZO: Yes, it was a rhetorical question yesterday, but now I'm rethinking that maybe it could be answered. We can look at the bids and look at the distribution of the dollars and the bids by large categories, but what is happening in 2009 is that CMS issued a notice of data collection for additional utilization information. So, beginning in 2009, they're going to get more utilization information than they currently get, and this is not the encounter data collection, but this is a different kind of collection at a somewhat higher level but it is different categories of services and different admissions and so on, utilization, and then we'll go to the encounter data, which will give even more information.

So, at some point, we'll have enough utilization information to be able to answer your question.

MR. BUTLER: Just take Part A and Part B.

Usually, the thrust used to be, get your days per thousand down, get them into the ambulatory -- all right intent. At that level, is there some indication? So you don't know.

MR. BERTKO: The only thing I would respond to you is that, on the HMO side, the plans are below the benchmark because they have been relatively successful. I mean, Jay's closed group organization is one example. I was associated with a plan where, in South Florida, we could bid well under the benchmarks because we controlled days per thousand, imaging -- I mean, we've had presentations on radiology benefit managers here. We used them because we could control imaging that way, and any other number of things. Success is uneven across the country, even in the HMO branches, but there was a fair amount of success in reducing some parts of utilization.

MR. BUTLER: My point was that not only do you get equal levels of performance economically but, in fact, they may be distributed in a way that is more beneficial to the people receiving the services. That's what you'd like to see and if we could demonstrate that I would be more encouraged in some of the other data on the fee-for-service plans.

DR. MARK MILLER: Just to make another connection to your point, another piece of work that Carlos and John Richardson are up to is, can you make, as part of the mandated report, which we have to get right back to after we finish this phase of work is, can you make a comparison in terms of quality between fee-for-service and managed care? And so, what the Commission has been tasked with is laying out how that process would work so that question could be answered, too, because you're asking two questions: what does the utilization look like across these types of service? Do the outcomes look any different? And the fortunate answer to both of those questions is, we're still a bit away from being able to answer either of them because were not collecting the data in a way that allows us to make those comparisons.

But the mandated report on quality is Congress asking this Commission specifically to tell them how to do the quality piece of it. And then, hopefully, the encounter database, which everybody is brought up many times, will start to flow. And if it doesn't, we should probably rant at some point about getting it moving.

DR. CROSSON: I actually do have a question, just

to continue this discussion for second. I think it probably is important to understand that there is another side to the data question. One of the reasons why we don't have the data is that one of the inherent efficiencies of a prepaid program is not doing the paperwork involved with billing. And so, over the years, I think we have enjoyed a level of efficiency because we don't have to do that.

What that leads to, though, is an information gap. And then, sometimes, it works, quite honestly, to our own detriment, which is that we are unable to demonstrate the reason why we're different.

So, we're moving ahead with the reporting as it is now, but it isn't that nobody thought about it before. It's sort of accidental that we don't have this information.

The question I had, and I think Mark was just beginning to get to that, and I hope this is a clarification, is sort of, where are we in the work plan?

Last month, we were going down the path of blended benchmarks and then the whole issue of changing the geographic units, and now we're doing this, and I know we're going to get to recommendations at some point. So, could we have a sense of where we are in that?

DR. MARK MILLER: Right. And again, for all of the Commissioners and the public just to understand, we're required by law to do update recommendations and put out the March report, which has certain characteristics dictated by law. So in a sense, we're kind of pausing the workflow, doing this mandate. We're going to come back and we've already done some of the parts of the -- now, I'm talking about the report that Scott and Dan are mostly working on, where we talked about looking at different geographic areas and the correlation between costs and bids, which was part of the mandate. And now what we're up to is starting the next time we start walking through with you guys will be, are there different ways to think about how the benchmark gets set? And that will be kind of the next phase.

As part of that discussion, I know that Glenn will -- who's reaching for his mic. I think I'll just let him go ahead and take -- will want to be talking, I think, some about what are our objectives here, with the program.

MR. HACKBARTH: For the March report, we're going to include in the data and update on enrollment and information about the dollars and where they go and all of that stuff and rerun our prior recommendations. Until a

year or two ago we didn't necessarily do that each year in the March report, but we were asked by people on the Hill to begin doing it, and they were actually able to point to some language, as I recall, in the statute to say that this is something that MedPAC is required to do each year in the March report, is repeat where we are on Medicare Advantage.

And so, the last couple of years, that's why you see us get out the old recommendations, rerun them in the report, and then coupled with an update on the enrollment data and the like.

The mandated reports, as Mark says, are a separate activity which we will take up again -- I guess, are we going to start on the January meeting with that? And that will be published in the June report.

Anything else, Jay?

DR. CROSSON: [off mic] Not on this part.

MR. EBELER: Thanks. I hope I'm not phasing into phase two, but I want to just connect Mike's question and Nancy's. If you go back to ten, the analysis here just applies the load, as they said, to the benefit enhancement dollars, as Carlos said.

I think a variant of both your questions was, how

do we think about the load applied to the bid itself? The question is, could one apply the load to the bid to get, again, the split between load and payout on the bid number as well as the split between bid and payout on the benefit number?

MR. ZARABOZO: Yes, and at a very aggregated level.

MR. EBELER: And I think the caution is -- the truth is, the beneficiary on the bid is getting the A/B benefit, so the piece here is literally benefit enhancement for the beneficiary. So, it's a different thing, but one could do that.

I think that would be the beginnings of helping answer some of Mike's question about why is something higher or lower.

I think it gets a little bit, Nancy, to what you were probing about a little bit. I just wanted to make sure that was possible.

DR. CHERNEW: [off mic] Can I ask another clarifying question?

MR. HACKBARTH: No.

DR. CHERNEW: I will do it in writing.

In response to Jack's comment, if I look at, say, the 108 for the local PPOs in the bid with load -- so, some part of that's load, and then, some part of that is what? Of the 108 that's not load -- it's not that they have higher prices, you've answered that. It's not that they have a worst-case mix, you've answered that.

John said it might because of the administration, but I would have thought that was actually what load was.

MR. ZARABOZO: In the case of the PPOs, one thing is that they provide in- and out-of-network coverage, which would be more costly than network-only coverage, presumably. So you expect their bid for the Medicare A and B benefit package to be higher.

MR. HACKBARTH: Actually, it simplifies the discussion if you focus on private fee-for-service. And so, you're assuming, as John says, that the prices are neutral, they're deeming, and so they're using the Medicare price structure.

DR. CHERNEW: So is the 13 percent the load? That's just what it -- the width load is the 13?

MR. ZARABOZO: Yes, it cost them 13 percent more with the load to provide --

MR. HACKBARTH: But he's try to get how much of that is the load versus --

MR. ZARABOZO: I can turn to John if he wants to answer that.

MR. BERTKO: I'm afraid I'll decline to answer it as I might identify a certain company, but you're on the right path, Mike. I mean, the amounts for the industry that are above, in this case, in private fee-for-service above the Medicare benefit, are in fact administration and profit, for the most part.

MR. HACKBARTH: It's load.

MR. BERTKO: Yes.

DR. HARRISON: Mike, some of the -- like, sales costs, marketing costs, can be really high for some plans. Like, private fee-for-service, we were hearing reports of commissions of $500 to $1,000 which --

DR. CHERNEW: That's in the load.

DR. HARRISON: That's in the load?

MR. BERTKO: Yeah, although amortized, usually, over the life of the contract.

MR. EBELER: My only suggestion is that we don't you to answer this now off the cuff, but it strikes me is

that the request is at least to do the calculation at the aggregate level so people can see the differences.

MR. HACKBARTH: Any other clarifying questions?

DR. KANE: Do we know what the marketing arrangements are for these different plans? You mentioned the agency commission. Do we have a sense of how much that varies among these plans, and how that might play in the differences in the load?

MR. ZARABOZO: This is another item of information, or kinds of information, that CMS will be collecting next year. They had specified for next year more information about the marketing practices and so on.

MR. HACKBARTH: Okay, let me see hands for round two, questions and comments.

DR. CROSSON: Thank you. This is basically just a request in terms of the drafting of the March chapter.

In reiterating the recommendations, as I remember, having sat through the discussion and the vote, which I remember a lot about --

[Laughter]

DR. CROSSON: One of the things I talked about and I think we discussed was the issue of phasing this change.

Obviously, different organizations probably have different needs for that, certainly one like our own with a fixed infrastructure is going to take a little time to adjust to the revenue change. There are also, without overstating it too much, they're also some adjustments that I think the beneficiaries are going to go through as, in fact, the added benefits are withdrawn. So, I would just ask that since we have recommended phasing in the past, that as we draft this we reiterate that recommendation also.

MR. HACKBARTH: Is the plan to include -- I think last year what we did was take the old recommendations and put them in a text box. Is that the plan for this year, as well?

DR. MARK MILLER: It was. I think we might need a little more commentary to make sure that we capture Jay's point. I can't visualize the test box right at the moment but I don't remember if -- yes, that's what I thought.

So the answer is yes, and you're right, that was part of the discussion. We will make it work, whether it's text box or otherwise, I think we can make this work.

DR. KANE: I guess I'm a little foggy about what we've already got going on a recommendation and is going to

be happening and what is sort out there vaguely. So there's a couple of things that sound like they might be coming but it's not clear what form they're coming, and it would be really helpful, I think, for us to think about, how do we clarify what kind of information we want and some kind of a deadline on it?

So, for instance, on the encounter data on commission structures and on administration versus profit -- those seem to be elements that we'd really like to know and would like to know in a format that -- for instance, for the -- encounter data lets us compare fee-for-service utilization with the managed care data.

I'm just getting worried that it's too vague, and we are going to get back is going to be too late and also not in detail enough for us to make reasonable conclusions from.

So, I just wonder if we need to be more specific about what kind of data and when we want it, and why then is out there. I get this feeling that we don't know much and it's five years or whatever it is into this.

MR. HACKBARTH: Let me focus on one facet of this, and that's the encounter data, which clearly a lot of people

have an interest in.

Jay described an issue that exists, a very real issue that exists for organizations like Kaiser Permanente. It's not that they've got this data and they're not providing it. It's that it requires an investment to put the systems in place to do it.

And so on that issue, for us to establish a timetable, I think, requires some level of research and thought, as opposed to just saying, well, we need this information next year or in two years. So, the question is whether we want to invest the level of effort and thought to put together a reasonable schedule.

DR. KANE: I think you're right about Kaiser, but I think a lot of managed-care plans aren't paying capitated amounts to their groups and actually do pay on a fee-for-service basis within and do have that data. I would say if you're paying capitation maybe you get three years, but if you're paying internally fee-for-service or have a utilization track -- I don't think -- they're not all that model. Most of them aren't.

MR. HACKBARTH: Absolutely, that's true. And even within that model, Harvard Vanguard -- because Harvard

Vanguard, which was principally a prepaid group practice, worked in a market that moved towards administrative services-only arrangements with employers 10 years ago or 15 years ago had to invest in putting in the fee-for-service data systems even though it's preferred model was prepaid group practice. So there are a lot of variations in this across the country that are market dependent.

DR. STUART: On this point, I think because the regulation has gone out and because the plans are on notice that they're going to have to provide these data and because there's a regulatory process that CMS is in charge of, I think, at the very least, we should be informed about what CMS's procedures are and when they are going to be developing those procedures and if they have a timeline in terms of when those data are going to be coming into the agency. And then, I don't whether they have a timeline in terms of what they're going to be doing, but at least to keep us abreast of what CMS is up to.

MR. HACKBARTH: I agree with that. It's an important issue and I'm not trying to drag feet on it.

I am reluctant for MedPAC to get in the business of prescribing timelines. That's not our area of expertise;

we're a little too far removed from the issues to do that effectively. But certainly, we ought to stay on top of this and be pushing CMS and have the staff get regular reports for us.

MR. GEORGE MILLER: My second-round question probably is a follow-up to my first-round question about data for minority populations. I guess I'm a little concerned that if the MA plans have enhanced benefits but those enhanced benefits are not getting to minority populations, there would be a concern on my part. However, I'm not sure how to frame that, as I said yesterday, if we're not able to gather that data. And I don't know if there's a mechanism to make sure that we can gather that data.

And then, secondarily to that, I'm a little concerned about the fraud and abuse that was brought up as far as -- I think you quoted Miami-Dade County -- and because of richness of this program, is that generating or germinating more fraud and abuse? If we can identify those numbers and then maybe make a recommendation to lower payments to deal with that issue? Those are two separate issues.

DR. HARRISON: I'm kind of thinking that we may end up addressing the so-called ratchet in the payment report and try to come up with something there. It's certainly a problem, and I don't think we -- I don't think we have a solution for it yet, so I think we need to wait for the payment report on it.

I don't think it would be -- I mean, these are fee-for-service fraud claims. The people who are perpetrating them are getting paid on the fee-for-service side. I don't think it's leading to more MA fraud.

DR. MARK MILLER: But to link it to his comment -- and we've actively been discussing this, we're just not ready to talk about it now enough to bring it up.

If we had some policy on the ratchet, at least it wouldn't spike, the rates wouldn't spike, because of the fraud and abuse that's occurring in the fee-for-service sector. So it's a bit indirect but it can address partially your points.

On the point on minority enrollment, back to a comment that Carlos made earlier, I think we can go through and tell you historically, just as long as you know we're a bit out of date, because we don't work with -- in all of

this analysis that we present here, rightly or wrongly, it's not a people-level analysis, it's more of a plan level. But historically we can, because that comes from MCBS?

MR. ZARABOZO: Yes, MCBS.

DR. MARK MILLER: So don't feel like we can't do anything there, just as long as you understand we will always be running a bit behind the train.

MR. GEORGE MILLER: That would be fine for me but in my part, as Michael talked about, that's an access issue, and we should make sure that the program is available to all Americans -- that it is available for all Americans. So that would be an access issue for me.

DR. CHERNEW: This was wonderful, and some attention to the ratchet I think is really important, so I'm big supporter of that.

Most broadly, I'm interested in understanding the potential impact of recommendation three, or the payment change that's taking it down to 100 percent of fee-for-service. So when I think through what would happen if you take this admittedly overly generous payment and move it down to a lower level, there are several things might happen. The first thing is plans might exit. Some of that might be good. There are

plans that aren't doing what we want them to do, and if they exit, that's probably fine.

And I think if George and I spoke long enough, we would probably agree that having no MA plans in some places, if it costs too much to get them there is probably okay, and we could deal with those problems.

Some of that exodus is my to be so good. We might not like the plans to exit for whatever reason. And what I'm most concerned about when they exit is that I believe that there's some amount of spillover between the MA plans and the traditional Medicare program. So, I think that we do this as if the fee-for-service, the traditional Medicare programs are what -- costs are what they're going to be, and Medicare is bidding against a fixed bundle, whereas I believe that having MA plans -- at least, real managed-care plans -- so that's -- not all of the MA plans are heterogeneous, but I believe there's actually some -- the magnitude of that we could debate, but some positive effect of MA on the practice of care in the fee-for-service area. Or put another way, the fact that Kaiser exists in California I think not only makes Kaiser cheaper, but I think it makes the fee-for-service in that area cheaper. I

think it gives them benchmarks for lowering length of stay. I think it gives them benchmarks for a bunch of things.

As a result, it's not clear to me that the ultimate target that I would shoot for would be 100 percent of fee-for-service because I think there's a bunch of reasons why I might want to encourage more MA than otherwise. I think 100 plus a bazillion percent, or whatever the number is there, is -- I can't remember, 118 percent or whatever it is on average -- the benchmarks have deviated too high. And in some areas, because of the ratchet effect and other things, I think it's deviated way too high.

But I think some more thought as to what the right benchmark should be relative to traditional Medicare and how that should be accomplished is -- by figuring out the impact of that reduction is important for me in thinking about that at least that's their recommendation.

MR. HACKBARTH: Yes, we can take a look at that, but I just want to underline one thing that you said.

The spillover effect may well be dependent on the mix of private plans that you've got and so -- but you set payment levels for all plans. So if what you want to

encourage is plans that have high spillover effects using just one payment level is a crude tool to achieve that result.

DR. CHERNEW: That's true, but if you think that the ones that would leave would be the ones that weren't doing a good job of managing care because they can't and the ones that would stay would -- so, if you lowered, you would think that Kaiser would stay, because they can do a good job on these numbers, and some of your less-efficient plans that have a very high administrative cost would be the ones to go. So, I do think you would get selective exiting. That's why I think some of the exiting could be good, but I do think you want to make sure you encourage the good type of managed-care plans to stay and attract the enrollees. And in order to do that, they have to offer some level of enhanced benefit.

MR. HACKBARTH: The reason, Michael, that I'm wary about this is that this has been a standard part of the rationale for this program, well, let's pay more money. The plans say they need more money but they are going to do good things with it, and that will also spillover to Medicare. That's been a part of the rhetoric for years and years and

years and, just trust us, it will happen; it doesn't.

DR. CHERNEW: I do think it's happened but I think there are different types of good things. They'll do good things and they'll give better benefits versus they'll do good things that will help rationalize the delivery system. And I do think there is --

MR. HACKBARTH: Not all Medicare Advantage plans are created equal, even within the HMO category. There's huge variation in performance on cost and quality, and again, payment levels are very crude tools to induce the sort of behavior that you're talking about.

DR. REISCHAUER: Which is why we have pay-for-performance rather --

MR. HACKBARTH: Exactly, and I think that's issue that we ought to bring into the discussion when we're talking about the payment report.

MR. EBELER: It's always a logical follow-up to that discussion.

I think there's three issues that the Commission needs to think about here. One is the payment level. I mean, if you go back to chart 10, you have the standing recommendation of why would one pay more for the same thing

just because you are called the Medicare Advantage plan instead of not? That's sort of the classic question and that's sort of the Commission's core policy.

The second issue that -- and we obviously have to deal with this report coming up -- the second issue is, even for those who say, well, there are some extra benefits here, and there are. The analysis on page -- sort of swinging from page 10 to page 11, says, in many cases there are, but it's not a particularly good buy. I mean, when you talk about $2 to $3 for one, you multiply that by the billion that we're really talking -- $2 to $3 billion in spending to get $1 billion in benefits from some of these plans, and I think that's part of what you're really trying to get to here.

I think the third issue -- and again, building off this last discussion -- is sort of begin to think about -- and I think Glen has articulated this -- what's the goal here, and what are the criteria we really should be setting for who we pay here? And the aggregate price alone isn't the only tool we've got for doing that. I mean, there's other tools. But if you really think through the goal, think through Peter's comments, you begin to try to think

through what one is trying to accomplish with a private entity competing against the Medicare program? What do you get out of that? I just think that you need to use more than the aggregate price to be the sorter, because, I mean, I don't think there's a lot of evidence over the last 25 years we've had this program that just the price alone does it. I mean, I think -- so, I guess I'm just encouraging us to think in those three buckets rather than one.

MR. BERTKO: I'm going to go back and follow up a little bit of Jay's comments and maybe part of Mike's comments.

The Commission's on record for getting to 100 percent of fee-for-service. And Mark, I think you said you were going to repeat some of the stuff, and I'll use the words glide path. A couple of years ago, I think we had three or four glide paths there, and to encourage making use of a competitive model, or thinking about it in terms to getting there, right now we have benefit competition, and the one I'm most familiar with is south Florida, and partly because of fraud and abuse, there are just tons of benefits there, and plans compete on getting the richest and best possible mix of benefits. If we can possibly change to that

a price-signal competition, and there are some ways to think about fixing a benefit package of some sort, then I think you could begin seeing things. And rather than have arbitrary reductions, use price signals to, in effect, say, in south Florida, we ought to be 10 percent under fee-for-service because of the fraud and abuse. Maybe in Cleveland, we're 5 percent under, and in Milwaukee or somewhere in rural Montana, we can never get under, but to be sure that we include some thinking along those lines, if possible.

MR. HACKBARTH: Just to pick up and build on John's point, some people who haven't focused on this program get confused by the language and they hear the bidding and they say oh, this is a competitively driven program. Historically, MedPAC's reservations with Medicare Advantage have not been about the bidding piece of it. The problem is in the benchmarks which have nothing to do with competition. They are in administered prices, indeed, legislatively set prices, and that's the flaw in the system. It's not the bidding part most of all, it's the benchmark part. It has nothing to do with competition.

What John is proposing is you could start to set benchmarks based on competitive price signals. They are

important issues that come up in talking about that, but it's taking competition to a whole different level.

DR. MILSTEIN: One observation and a couple of suggestions.

First, I just want to remind everybody that even though our information on quality comparisons, plans versus Medicare fee-for-service, are not what we would like them to be. They are not zero, those comparisons, and the comparisons we've looked at do not suggest, on average, any advantage to the plan. I just want to clarify that because some of the prior comments suggested we were completely in the dark. We're not completely in the dark. Carlos has laid out what we know and it does not favor MA plans on quality.

Assuming that we actually want extra benefits, this is a time in Medicare's history where we want to start buying up benefits -- which I won't comment on, but assuming we are, I would be interested in knowing, referring to slide 11, how Medicare's cost in paying Medicare Advantage plans to be vehicles for delivering extra benefits, I'd like to know how that compares with, for example, how much it costs Medicare beneficiaries to buy extra benefits through med

supp plans. I mean, is this -- in other words, is $3 for every benefit gained, is that competitive with what the beneficiaries themselves were willing to pay for extra benefits through med supp. I would be interested in -- understanding that the content of the benefits is different, but nonetheless, this opens up a vehicle for understanding whether or not MA plans as currently implemented are an efficient system for delivering extra benefits. So, it would be helpful for me to see how it benchmarks with med supp plans.

Last question is, as long as we're opening up this in a full way, given the current environment, should we also, in this chapter, explore, in the unlikely event that MA plans actually do come in under Medicare fee-for-service -- It's theoretically possible, according to Hal Luft -- but if it were to actually happen, is 75/25 the right split, versus other methods?

And last point is, concurrent with all this, we have other ideas that we've put before Congress on how to deliver the Medicare benefits package more cost effectively, i.e., accountable care organizations and medical homes.

And so, should we, in this chapter, in the event

that -- in a given geography, no Medicare Advantage plans are able to come in under what is hopefully a more rational benchmark? Should we, in this chapter, raise the possibility of this, in essence, subsidized marketing advantage, being directed toward accountable care organizations or medical homes that -- in the event they are more successful than the plans have been at reducing Medicare spending and delivering better quality?

DR. STUART: Two points, and one is something that everyone here is familiar with but I think that it's important to have it in the record. That is, historically, when the HMO benefit was first risk-based following TEFRA, that the payment rate was 95 percent of fee-for-service, not 100 percent, and there were plans that founded a business model that they could operate under that. I don't know whether there's anything magic about 95 percent but it's below 100 percent. And so I think that when we're talking about where that number should be, we really do want to put it in that context.

The second point has to do with spillover. I think we look at these numbers and, because we're focusing on Medicare, there may be a natural tendency to assume that

Medicare is driving the market here, but historically, I don't think it worked that way. I think the reason that there were HMOs that came into Medicare is not because they were created to deal with Medicare, it's that they were already around already and they found this to be a way in which they could expand their market. Now, maybe some of that is changing, but when I look at these numbers it doesn't seem to be changing a whole lot on the HMO site. Now, maybe it is, but the real numbers are coming in on the PPO, and particularly the private fee-for-service side. It may be that we want to investigate this a little bit further in terms of who's driving which market, but historically at least, I think it's pretty clear that the private sector preceded Medicare managed-care plans.

MR. HACKBARTH: Okay, any other questions or comments?

DR. CHERNEW: As we go forward, I think it would be very useful for me to understand a prediction as we follow our recommendations, as to what we think would actually happened in the MA program if we did this in terms of plan participation by type and by area.

So right now it seems to be driven by a

philosophical view that the playing field should be level in one way or another, which I think is a reasonable philosophical view. But there's a separate way of thinking about it in sort of a cost-benefit sense, if we were to lower from this to this, what would happen? What do we think plans would do? What do we know from the literature about plan entry and exit and stuff? That would be useful for me to know in thinking about the third recommendation.

MR. HACKBARTH: To me, the first step in this process needs to be what are your goals? What are you trying to achieve? Then, you figure out what payment systems promote those goals.

We know, generally speaking, from prior experience, that you lower payment and you get less participation. The question is, is that a good thing or is that a bad thing?

Right now, de facto, the policy goal is we've got to have plans everywhere and we've got to pay enough to get plans everywhere. That's what the de facto policy goal has become and that's how we are where we are.

And so, just looking at what's the effect of payment on participation, I don't think is a very effective

policy guide. You need to be very precise in what the goals are that you're trying to achieve. That's not a step for this discussion in the March report. That is a critical step for our June report. So, rather than trying to take that up right now in an unfocused way, I would suggest we move on and we'll come back to these issues. There are several important threads to pick up for the June report and we'll do that in January.

Any other questions on the narrow issue for the March report: an update on benefits, enrollment? Anybody else? Thank you Scott and Carlos.

Next we have the Part D formulary discussion.

DR. SCHMIDT: We're pleased to have with us Jack Hoadley of Georgetown University, along with his colleagues, Elizabeth Hargrave of the National Opinion Research Center at the University of Chicago, Katie Merrell and Lan Zhao of Social and Scientific systems.

They've been looking at the formularies of Part D planned sponsors, the ones that they'll use for 2009, the upcoming benefit year.

Formularies are one of the most important tools plans have to help manage the use of prescription drugs. A

formulary is a list of drugs that the plans cover, and the terms and cost-sharing requirements under which they'll cover them.

We ask Jack and his colleagues to describe the balance that Part D plans are striking between providing access to medications and controlling growth and drug spending, and we're going to incorporate some of this information into our March report.

DR. HOADLEY: Thank you. I'm glad to be back here. We've talked about these formularies, but it's been a while.

I want to talk about three things primarily, today. I want to talk about tier structures, the particular ways that plans design and structure their formularies. I want to talk about cost-sharing, the amount of money that's charged for drugs on different tiers, and then formulary sizes.

And I want to emphasize that the results you'll see are all for 2009 formularies, the formularies that will go in effect next year, and then of course comparisons back to 2006 through 2009.

And for all the analysis, we're doing weighted

analysis, weighted by enrollment. Of course, we don't have 2009 enrollments at this point, since they haven't existed yet. So, the 2009 results will be weighted by the 2008 enrollment levels.

So, in terms of tier structure, there's really become kind of a single most common tier structure. The law called for a standard benefit design that had 25 percent coinsurance across the board, but for the most part, that's not what plans are doing, as I'll show you on the data on the next slide. But for the moment, emphasize that the most common tier structure that we see out there includes a single tier for generic drugs, two tiers for brand drugs for preferred and non-preferred, and then sometimes some of the higher priced generic drugs get included in these two tiers, and then a fourth tier for specialty drugs, a specialty tier that applies to drugs that are more expensive, must have a cost of at least $600, and those tend to be biologicals, often injectables, but not always.

So, that's the standard tier structure that seems to have evolved in the marketplace. There are a number of variations, as I'll show you in a moment, and that primarily refers to situations where plans use only a single-brand

tier instead of having a preferred and non-preferred.

Some plans that more recently have added a second generic tier, either a non-preferred generic tier for some of the more expensive drugs, or what they'll sometimes label a value generic tier for drugs where they may charge a very nominal copay to try to create more incentive to use those particular drugs. And then, some plans have, instead of or in addition to their specialty tier, have what they'll call a non-specialty injectable tier.

So, here are the numbers, and you'll see that the red bar there referred to the plans that have this -- what I call the most common tier structure with one generic tier, two brand tiers and usually a specialty tier, has become really the dominant form.

You'll see that the light blue bars are the defined standard, 25 percent coinsurance, and those have almost disappeared, down to 7 percent of PDPs and only 1 percent of the Medicare Advantage drug plans.

You'll also see the pink bars up at the top for 2009 are the emergence of the new kind of tier structure with two generic tiers in addition to the two brand tiers and the specialty tier.

This gives you a sense for 2009. This is the first year that we've taken a look at the special needs plans, and you can see it's the special needs plans that really are using different tier structures than the other two types of plans, and they've really introduced two additional types of tier structure: the blue bar there, which are the plans that use 15 percent coinsurance instead of the standard 25 percent coinsurance, and there's a bar over to the left there that's sort of a light blue, which are plans that basically don't charge any cost-sharing at all. I call them free-tier designs. And those are two things, both of which occur on the dual-eligible SNPs. It's only on those kinds of SNPs, not on the other kinds of SNPs. And so, those are tending to show up in the SNP world as a different kind of plan.

In terms of specialty tiers, I said before that a specialty tier is available for more expensive drugs. When CMS created the guidelines for specialty tiers, they specifically called for this kind of tier as something that plans could use, and created two rules around it: one is this notion that it has to be expensive drugs, which they've defined as $600 a month or more, and secondly, that when a

plan uses a specialty tier, beneficiaries cannot request a tiering exception. In other words, they can't request that a drug that is normally covered on the specialty tier be made available to them for one of the other tiers, and thus at a less expensive price.

So, this shows what share of plans, excluding the plans with the standard benefit design, which of course doesn't lend itself to any kind of separate tiers -- what percentage of the plans use specialty tiers, and you can see it is most of the plans, is actually it looks a little bit lower for 2009 on the PDP side. Most of the rest of the plans that don't use a specialty tier have a coinsurance tier structure. They don't use flat copayments at all, and so they have a preferred and/or a non-preferred tier that has 25 percent or higher, in some cases 50 or 75 percent, coinsurance for their non-preferred tiers. So, they seem to have made the judgment that, because they have those percentage coinsurance, they don't have a need for a specialty tier. We obviously don't know why they do it, but that would seem to be the kind of logic that's going on there.

Then, to look at cost-sharing, here we see the

median cost-sharing with a weighted median concept here. The median cost-sharing for different plans and how it's changed over the four years.

Here, I'm really focusing on the plans that use that standard structure. So, I'm excluding single-brand tiers and the two types of generic tiers when I do these kinds of numbers. And in the PDP side in particular, we've seen a gradual rise in the cost-sharing. You see it particularly in the preferred and the non-preferred cost-sharing for brands that have risen from $28 and $55 to $38 and $75. But even the generic has gone up this year from a median of $5 to a median of $7. It's been a little more constant on the Medicare Advantage side. There have been a few increases, but less so.

The other thing that's important to note here is the specialty tiers I've alluded to uses percentage coinsurance even for plans that otherwise use flat cost-sharing. In general, CMS guidelines say that specialty tiers should be at the standard 25 percent level, unless through actuarial equivalents; for example, having no deductible in the plan, they can make a tradeoff between the absence of a deductible or some other features and higher

coinsurance for the specialty tiers. So, by 2009, both in Medicare Advantage and PDPs, the median level of coinsurance for the specialty tiers is now 33 percent of the cost of the drug.

So, Bruce Stuart had asked a question at the last meeting about cost-sharing in the generic tiers, and sort of raising the point that, out there in the market, now, with the Wal-Marts and the CVSs have gone to this $4 monthly copay for generic drugs. How many of the plans have copayment levels for their generic drugs that are actually higher than $4?

Now, I should put an immediate caveat that the person is charged the lower of the actual cost of the drug or the plan's copay. So, if it's a drug that's being sold for $4 and the plan's normal copay is $7, the person still gets it for $4. But in fact, well over half of the plans in 2009 have standard copayments for their generic tiers that are over $4. It's 74 percent of either the PDPs or the MA-PDs have copays over $4, some as must as $10, or I think a couple of them go up to $12.

So again, it doesn't necessarily mean that people are paying these higher amounts if the drugs are cheaper at

the drugstore they're going to, but it does mainly mean they're essentially paying the full cost of the drug.

So, here, I want to turn from cost-sharing on to the size of formularies. And we've talked in my previous presentation on this about different ways you can define drugs. What we've settled on for the analysis is defining a drug as the chemical entity so that we lump together different forms, different strengths, and different trade names under which the drug is sold. So, brand and generic drugs are not distinguished. So, if a plan covers just the generic version of a particular form and strength, then they count as covering that drug. Now, in most cases, when they cover one particular strength, they cover multiple strengths. So, that's normally not a distinction that's made, but for purposes of definition, we're asking how many of the chemical entities are covered.

Similarly, the percentages here represent -- CMS puts out a reference file that basically indicates the universe of drugs that might be covered. And so, what we've got here is the percentage among the chemical entities of the drugs that plans cover, and you see on average, plans are covering nearly 90 percent of all the chemical entities

that are on the CMS reference file. It's gone up a percent or two or down a percent or two from year to year, but essentially that's been stable.

Then, to look at whether there are differences between the PDPs and the other types of plans, this presents the 2009 data. And between PDPs and MA-PDs, the numbers are very similar.

Here, I'm also showing the range with the minimums and the maximums, but 86 percent on average covered by PDPs, again, weighted averages, 88 percent for the MA-PDs.

Where it's a bit different is in the special needs plans which, on average, are covering only 71 percent of the chemical entities. And I'll come back to some more on the special needs plans and the differences in a couple of slides.

Another question that seemed interesting to look at is, do the plans that are eligible for low-income subsidy enrollees look different at from the plans that are available to everybody else? And the answer is, not very different, but there definitely is a difference, and it's been growing.

So, in 2007, there was only about a 4-percentage

point difference in the percentage of drugs that are listed on formulary between the non-LIS plans and the LIS plans.

By 2009 and 2008, that gap had grown to 10 percentage points. So in 2009, the non-LIS plans are covering -- are listing an average of 89 percent of the drugs, and the LIS plans are listing an average of 79 percent of the drugs.

Now, it's important to think about the fact that just the number of drugs listed on formulary really isn't the whole story. You can list a lot of drugs and make them hard to actually get. You can list fewer drugs and make them easier to get. You can get drugs that are off formulary through exceptions. You can fail to get drugs that are on formulary because of other restrictions. So, we developed a measure of unrestricted versus restricted drugs, and basically here we're showing you that unrestricted drugs are defined as those drugs that are not on a non-preferred tier. In other words, they're either on a generic tier, a preferred-brand tier, or a single-brand tier for those plans that have that, and drugs that don't require any kind of utilization management permission. So, there's no prior authorization, no step therapy, and no quantity limits.

So, the first question is, how often are these prior authorization and other utilization management tools applied? We have found there's actually been a gradual increase in the share out of the drugs listed on formulary for which utilization management is applied, and it's gone from about 18 percent of all listed drugs in 2007 to about 26 percent in 2009. The MA results are very similar; I'm only showing you the PDPs. And there's been a small increase for each of the three types of utilization management tools: the prior authorization, the step therapy, which is the least commonly used, and the quantity limits.

So, here, we'll give you an example by showing some of the largest plans of how much there is a variation among plans both in the size of their overall formulary and to the extent to which the formularies are restricted or unrestricted. And you see here that -- and these are basically the five biggest PDPs based on 2008 enrollments, and it's a little hard to define MAs for this purpose, but basically these are five of the largest MA plans based on 2008 enrollment.

And here, we're defining MA plans that share a particular tiering and cost-sharing structure. And you'll

see that it varies quite a bit. There are plans that list as many as 100 percent of their drugs on formulary to as few as 64 percent, but there's less variation in some cases among the unrestricted drugs, the light blue part of these bars. And so, among the PDPs, there's a lot less variation in the amount of drugs that are unrestricted compared to the variation in restricted. So, where they add drugs, they're adding them in these restricted forms.

And you can see that also among the MA. Kaiser Permanente is a case that has one of the smallest formularies overall, but they have actually the highest of this set of examples in terms of drugs that can be obtained without restrictions. So, it's different strategies applied by different plans to use their formulary, and it makes the point that just because the formulary is the largest doesn't make it the best formulary.

So, looking at some of the kind of variations by different plan characteristics, we did see that the PDPs that have more tiers tend to list more drugs. So, when they're adding these additional tiers, they're tending to add drugs in those tiers. Obviously, that isn't the case for every plan, but that seems to be the pattern, but the

number of unrestricted drugs, the number of drugs that are on those preferred tiers and don't have restrictions tends to save pretty similar.

One interesting question is, do the plans with enhanced benefits have larger formularies? And the basic answer is, no. Whatever is being enhanced about these benefits is not the size of the formularies. It's cost-sharing difference, it's deductibles, it's gap coverage.

The larger PDPs, the ones that have a larger share of their regional enrollment do tend to have larger formularies. That may suggest that people are seeking out the plans with the larger formularies. And we also, among the MA plans, saw that the local HMOs have modestly smaller formularies than do the private fee-for-service plans or the PPOs.

Finally, just looking and coming back to the question of the special needs plans, we tried to break out the different kinds of special needs plans, starting from that previous observation that special needs plans on average have smaller formularies than do other Medicare Advantage and PDPs.

Here on the right we've got the Medicare Advantage

plans. You see that the SNPs that are offered for chronic and disabling conditions look very similar to those in terms of formulary size. It's the dual-eligible plans the institutional plans that have small formularies. But again, here, like in some of the other results, you see that the number of unrestricted drugs is actually pretty similar across these different plans.

And again, here, and especially for institutional plans, it may be that some of the arrangements made within the institutions, that the size of the formulary and the ability to get exceptions could be different than it is for some of the other kinds of plans. Again, we don't know that, but that's one possible speculation on why you might see a difference here.

And that's it. I'll take your questions.

MR. HACKBARTH: Thank you, Jack. Good to see you again.

Can I see hands for clarifying questions?

DR. CHERNEW: I feel so privileged to see all this data, what seems like early, but is there any information on how the premiums for these plans were late to these other aspects of the plans in the formularies?

Obviously, when you showed some of the ones up there, you had the saver and the preferred. And so, how premiums are moving is as important as how these things are moving. And maybe you have some sense of that.

DR. HOADLEY: We did not actually yet, this year, do that correlation and look at high premium versus low premium. When we've done that in previous years, we've actually seen very little correlation between premium amounts and the size of formularies or even the amount of restrictions on the formularies. It would suggest to us that premiums -- first of all, we know premiums are driven by some of the enhancements like the gap coverage, that certainly is correlated with premiums. But even among basic plans, we have generally not seen any kind of correlation, but we do not actually look at that yet for 2009 to see if that has started to become a difference.

MR. BERTKO: Just a comment to add to Jack's presentation. When you're looking at the LIS, many of the comments about tier structure disappear because of the extra cost sharing subsidies that come into play. What is it, about a $1.50 and $3.50 or $1.25 and $3.50 these days?

The comment that I would add to that is that, in

terms of cost control, then, the utilization management controls and tighter formularies such as one of the plans up there who is a PDP had a very small formulary with a very large proportion of LIS members would come into play. And that then is connected with the presentation we had from John Hsu on the risk-adjusted amounts for these a couple of months ago.

DR. STUART: Thanks Jack, this is really interesting stuff.

I would like you to go back to slide seven, if you can. This is an interesting slide for a couple of reasons. First of all, it's the only slide in which we get some sense of what the distribution is around the medians. And so, thinking about the other slides where we have the medians, the medians are important, but it would also be interesting to know what kind of variation we have on either side of it.

My question, and you indicated that this was driven by a question that I had last time about the $4, on the MA-PD side, do we have any sense of the number of plans -- and maybe this isn't directed to you, but rather to other Commissioners who have more knowledge about this in the market -- the number of MA-PD plans that would have their

own of pharmacy and so that the copay amount would in fact be the actual payment amount rather than the lower-then?

MR. BERTKO: I think own pharmacy, to the best of my recollection, varies. Jay's company has their own and a couple of the other major companies have owned PBMs, so it's the difference between owning the pharmacy itself, and then others, like the company I was with, contract out for only the administration of the PBM but retain all of the contracting and formulary decision-making. And yet, there's another group that contract out for the whole thing to independent PBMs, so it's across the board.

DR. STUART: If I could put that in other words, if we look at this chart and we see the 74 percent of MA-PDs in 2009 that have copays above $4, how many would you guess of those would beneficiaries actually be forced to pay the higher copay as opposed to paying the $4 if it were available in their market?

MR. BERTKO: I will let Jack talk to that, but I think the answers is almost none, because I think most PDPs and Ma-PDs would charge the amount of either the lower of cost or the copay.

But Jack, do you know that exactly?

DR. HOADLEY: We don't know empirically. Certainly in practice it seems to be close to universal that plans will charge the lower of cost or the copay.

In fact, in the regulation that was proposed earlier this year -- would eventually turned that into a requirement, but that actually hasn't been converted into final reg yet.

But there's another level of the question, which is, if a plan owns their own pharmacies, they may simply set the purchase price of the drug -- I don't know how that always works, if a drug is fundamentally cheaper so they if they can get hydrochlorothiazide for $2 for a monthly supply, but their standard copay is $5, presumably they're still making that available at $2 to the beneficiary. But I don't know how Kaiser Permanente, for example, which is one of the few plans that really owns the actual pharmacies that are dispensing to the members, how they would handle that kind of a situation.

DR. STUART: We're not really talking cost here; we're talking sales price.

DR. HOADLEY: True.

DR. CROSSON: I'd like to be able to answer this

but I don't know, so I will look into that and maybe we can talk about it.

MS. HANSEN: Thank you. I'd like to ask a question about the low-income subsidy group, because the nature of the beneficiary is that they have fixed pay, but there is a subsidy, as you were saying. I was talking to one of the colleagues at AARP that -- is it accurate that, given the specialty drugs that are used now are about 6 percent of the population is using specialty drugs, but 90 percent of those are somewhat covered by low-income or actually taken by the low-income subsidy.

So the question behind it is, do they become in some ways a group that gets focused on because there's actually not the personal copayment or the coinsurance on the part of the beneficiary that the government is actually paying so that there's a possibility that this group becomes a good group to make sure get the specialty drugs?

DR. HOADLEY: I'm not sure what the data would show in terms of who's using the specialty drugs. CMS has started to run some numbers on that, which is probably what you're referring to. Certainly from the perspective of what's paid if the specialty drug has a 25 percent or 33

percent coinsurance but the low income beneficiary, the subsidized beneficiary, is restricted to the $3 or the $5 copay and in fact, if they get up into was otherwise the catastrophic coverage, then they have no copay at all, and so somebody is using those expensive drugs would end up with no copay.

The government is picking up the part that the beneficiary normally would have paid. So, the government would be picking up the difference between the $5 or $3 and the 33 percent or the difference between the three or $5 -- or the zero dollars in the catastrophic and the 5 percent that somebody would be paying in catastrophic coverage, and then the plan would be responsible, subject to all the other aspects of the benefit rules for the rest.

MS. HANSEN: Good. I just was wondering that that's something that is on a watch factor right now, as to how that is perhaps targeted for one group.

The other thing is, this year I noticed that we're making sure that people really take a look at what their current drug plan is, because many people tended to go into something and not have a tendency to change. But this year is such a significant one in that the risk corridors really

seem to widen.

Is there some change based on the way the plans are also covered by a subsidy in some way that changed this year that suddenly now this copay percentage is so much higher than before?

DR. HOADLEY: Yes, the risk corridors opened up last year for 2008, for the last year that people were choosing for a year ago. The effects of that change in the risk corridor is something that we would expect to play out starting with the 2008 benefits and continuing in 2009.

I don't know that I would necessarily link that to the changes in the cost-sharing. I would guess that would more likely show up at premium-level effects or other kind of things that affect just how plans are behaving in the market.

I think the cost-sharing changes, to some extent, is simply reflecting the increased cost of some of the -- and again, it's been especially for the brand-name drugs, because plans do have to continue to establish the actuarial equivalents of their flat copays to the 25 percent average coinsurance. And so, if the average cost of drugs are going up or price of drugs is going up by 10 percent, then on

average those flat copays should go up about 10 percent. So I think that is certainly a part of was driving that.

Now, plans have a lot of discretion. They can be shifting copay between their generic and their brands or between their specialty and the generics and brands, and we see quite a bit of variation in some plans that have zero copay for generics and quite a bit higher for brands, some are much closer in terms of the gap between their generic copays and their brand copays.

DR. KANE: To follow on Jenny's question a little bit, do LIS plans have a higher percent coinsurance in the specialty drug part knowing that -- and would that translate into helping them have a lower price? And then, because the government plays, it's actually fine, because the enrollee doesn't have to pay? Is that what you are trying to get at?

So would plans that are eligible for LIS enrollees purposely keep their coinsurance for specialty drugs relatively high, which would give them a lower overall premium, but because the enrollee doesn't have to pay that, but the government does, would that be a reason that their prices were lower? And maybe John knows the answer -- was that your question, Jay?

MR. BERTKO: I'll give you what my opinion is since I'm gone now couple of years, and it actually is the other way around. As we've found from the risk adjustment perhaps under reimbursement on this, you actually are -- in some cases you can argue that you're penalized for more LIS people as opposed to benefitting from them. So while the comments that you made are correct for enrollment in the way that part of it is reimbursed, on the whole you might be losing money with the more LIS people that you have in, but at the same time, these are open plans, and so anybody can come into any plan.

DR. KANE: But if I were someone not LIS, I wouldn't want to join a plan that had a 40 or 50 percent copay for specialty drugs, I'd want one that had a lower coinsurance, rather, for specialty drugs, but a LIS person is going to be insensitive to that. But the premium will be lower so the government will say that, now you are eligible, but the reason is because the government would pay a much higher coinsurance.

MR. BERTKO: Yes.

DR. KANE: Is that a possible strategy for a plan to keep its premium at LIS-eligible levels?

MR. BERTKO: It's possible if you wanted to attract the LIS members again, but again, my comment was, you may or may not want to.

DR. HOADLEY: And certainly some plans, even though there are reasons to avoid it and we've seen some plans seem to work themselves out of the LIS market; other plans are clearly very much in it, and so, it certainly is possible.

The only other caveat I would add is that the actuarial equivalence is still a requirement that is going to have to apply. They've got to have the whole package of cost-sharing still work out to match the 25 percent. The deductible gets figured into that. I mean, there's a number of calculations in that.

DR. MARK MILLER: I don't want to keep the ball in play too much longer, but I also was under the impression from other work that we've seen is that the use of the specialty tier is going up and it's pretty broad-based. It's not just LIS types of plans?

DR. SCHMIDT: Yes, I think that's true. It's a small share of all enrollees who are using those drugs but the expenditure is disproportionately high and increasing.

DR. MARK MILLER: What we've seen in the last few years is a lot of movement to having a specialty tier across a broad range of plans. So there may also be something going on that's not so much a LIS/non-LIS as more as -- right.

DR. HOADLEY: And certainly some of the data have shown that the LIS folks use a lot of specialty drugs. It's also the LIS people in general use more drugs on average than non-LIS people across the board, and specialty is part of that.

DR. MILSTEIN: One of the innovations now beginning to seep into private sector drug coverage is the ability -- or not the ability -- is essentially varying the benefit depending on the patient's diagnosis. Other than through the vehicle of prior authorization, A, is it occurring? And B, would it be legal under Part D plan rules?

DR. HOADLEY: Certainly there are some SNPs that have made some efforts in that direction. I haven't looked in a great amount of detail at those and maybe others on the MedPAC staff have done that.

The new value generic tier that a couple of plans

have introduced could be a part of that where they're making a select set of generic drugs very cheap as an incentive to use them --

DR. MILSTEIN: I'm sorry. My question pertained to diagnosis specifically.

DR. HOADLEY: I understand. The only way you would see it through, particularly, the standalone PDPs is going to be by categories of drugs, because they don't really have a chance to look separately at the patient's diagnosis.

DR. SCHMIDT: In fact, they're required to use the same cost-sharing for all enrollees in the plan.

DR. HOADLEY: Yes, they could put all of the cholesterol drugs less expensive on a lower tier or something like as a way to get at that, but they would also have to meet the nondiscrimination requirement, which we usually think of as down on the negative side, but it would presumably apply equally on the positive side.

DR. MILSTEIN: Given that the incremental value of a particular drug might vary drastically between patients depending on their diagnosis, is this an area of flexibility in Part D drug rules that we ought to reflect on?

MR. HACKBARTH: It would seem that SNP is a potential avenue for that sort of innovation. It really runs counter to some of the very basic rules of the regular Part D program.

DR. MARK MILLER: I also think -- you would have to think very hard through what kind of a selection mechanism you would be creating there. This could have serious negative consequences. I know you're thinking, this diagnosis, this drug, I should -- but this strategy could be used for very different reasons, as well.

DR. REISCHAUER: Do we have any capacity to figure out whether under the copayment regimes here, participants are paying more or less than they would have if they were all in the standard kind of 25 percent coinsurance for generics?

You'd have to have volume information. You would have to assume that it didn't change when you went from one regime to the other. I'm just wondering, does all of this end up with more or less being paid for generics by participants in these programs than if everybody had stuck to the standard plan?

DR. HOADLEY: One of the points is that -- if you

think about it, with the graph that Bruce was talking about, the fact that more than half the plans have copays for generics that are over $4. I don't know what the average price for a generic is but when I have looked at some of these kinds of things, we did an analysis, I think, in 2006 in some of the work we did for the Kaiser Family Foundation that suggested that, I think it goes right to your point, that the average percentage for generic drugs tended to be higher than 25 percent and you sort of see it in these plans with the $5 copays when there's a lot of drugs that can be bought for less than $5. So for many of those drugs, people are paying 100 percent of the cost, they're paying 80 percent of cost, their paying 70 percent of the cost, because the actuarial equivalent is 25 percent. It doesn't have to fall true in every category.

So, yes, I think the answer is probably for generics, on average, it's higher than 25 percent though it varies obviously by plan because if you've got a plan that's zero-dollar copay, the ones in that plan are paying, clearly, less than 25 percent.

DR. REISCHAUER: We also have to factor in somehow the deductible, which would make it even more complicated.

DR. HOADLEY: Exactly.

MR. HACKBARTH: Any other questions, comments?

Okay thank you very much, Jack.

Thanks, Rachel.

We will now have a brief public comment period.

Okay, we are adjourned. Thank you.

[Whereupon at 11:48 a.m., the meeting was adjourned.]