

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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Thursday, March 10, 2005  
10:03 a.m.

COMMISSIONERS PRESENT:

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

2 MR. HACKBARTH: Good morning. Before we begin let  
3 me just talk about the agenda of bit for the morning and  
4 immediately after lunch. We've done a little bit of  
5 rejujgling of the agenda.

6 On the published agenda the first item is Medicare  
7 Part D: Access, cost and quality issues. And then we move  
8 to Medicare Advantage issues. What we're going to do is  
9 take up a piece of the Part D discussion, namely the piece  
10 related to the premium setting process.

11 And then we will move the other Part D issues to  
12 immediately after lunch, for example, the discussion of the  
13 grievance and appeals issues.

14 The reason for splitting them that way is that we  
15 thought that the premium setting issues conceptually were  
16 linked to some of the Medicare Advantage issues that we're  
17 going to take up about how to establish appropriate payments  
18 for private plans. And so we thought it might be helpful  
19 and clearer if we proceeded that way.

20 So Part D premium setting issues and then Medicare  
21 Advantage premium setting issues and so on, with the  
22 remainder of the Part D issues immediately after lunch.

1           With that preface, Rachel.

2           DR. SCHMIDT: Good morning.

3           As one of our chapters in the June report to  
4 Congress, we're looking at several aspects of implementation  
5 of Medicare's new outpatient prescription drug benefit. As  
6 Glenn mentioned, Joan is going to discuss formulary  
7 exceptions, grievance and appeals issues later today. But  
8 right now I'm going to describe our ongoing work on  
9 geographic variation in drug spending and the process by  
10 which Part D premiums will be set.

11           The motivation behind this work really stems from  
12 the same sorts of issues we've talked about with respect to  
13 regional variation in Medicare's medical benefits under  
14 Parts A and B. We know that program spending for Parts A  
15 and B varies quite around the country and that higher  
16 spending regions do not necessarily have higher quality or  
17 better outcomes. However, we don't as much about those  
18 questions when it comes to prescription drug spending by the  
19 Medicare population.

20           For our longer term research agenda, we hope to  
21 address question such as those on the slide as they relate  
22 to Medicare beneficiaries. Obviously, we can't answer these

1 difficult question in much detail by June. However, we do  
2 plan to at least begin addressing the first and last bullets  
3 on the slide that are highlighted, and I'm going to walk you  
4 through some preliminary work toward that end.

5 Has everybody found the paperwork? It's kind of  
6 midway through the group on Part D at this point.

7 Our approach for this research is as follows.  
8 First, we looked at how the MMA envisions using private  
9 plans to deliver the Part D drug benefit. We also looked at  
10 how CMS will pay plans and the methods that the MMA calls  
11 for in calculating enrollee premiums. In this presentation,  
12 I will show you some publicly available data to look for  
13 evidence of geographic variation in drug spending for the  
14 Medicare population. For the future, we may also analyze  
15 some variation in drug spending for a sample of privately  
16 insured Medicare beneficiaries.

17 First, let's talk about Part D's approach to  
18 delivering an outpatient prescription drug benefit. It will  
19 rely on private plans, that includes stand-alone plans and  
20 Medicare Advantage prescription drug plans, to deliver  
21 benefits in 34 different regions around the country. Those  
22 plans will be at risk for the benefit spending of their

1 enrollees.

2           The MMA used this approach in order to give plans  
3 incentive to control growth in prescription drug spending.  
4 Private plans must offer a standard benefit or one that is  
5 actuarially equivalent to it within some specific  
6 constraints and Medicare will subsidize nearly 75 percent of  
7 the cost of that standard benefit. Plans can also offer  
8 supplemental drug coverage but enrollees have to pay the  
9 full premium of that.

10           The MMA provides for several different kinds of  
11 subsidies under Part D to serve the purposes that are shown  
12 on this slide. Direct premium subsidies, individual  
13 reinsurance and risk corridors are aimed at encouraging  
14 beneficiaries to enroll in Part D and encouraging private  
15 plans to participate. In addition, Part D has subsidies  
16 that will pay for some of the cost sharing and premiums for  
17 individuals with low incomes and low assets.

18           As I mentioned, private plans, both stand-alone  
19 and MA, will be at risk for the Part D benefit spending of  
20 their enrollees, but there's still a lot of uncertainty as  
21 to how many Medicare beneficiaries will enroll and how many  
22 plans will enter the market and where.

1           The MMA specifies that in the event that  
2 beneficiaries do not have a choice of two plans, CMS must  
3 contract with a fall back plan that will not be at risk for  
4 the benefit spending of its enrollees.

5           This is just a reminder of the structure of the  
6 Part D benefits with its doughnut hole in the middle, where  
7 the enrollee pays 100 percent cost sharing. And also  
8 remember that the catastrophic coverage of the standard Part  
9 D benefit kicks in after the enrollee has paid, in 2006,  
10 \$3,600 out of his or her own pocket with a few exceptions.  
11 That's called the true out-of-pocket provision.

12           Here's our nice color graphic showing you the 34  
13 PDP regions that CMS announced at the end of last year.  
14 Many regions are made up of single states but a few states  
15 are grouped together into a single region, most notably a  
16 seven state region in the upper Midwest. CMS picked these  
17 groupings for some specific reasons. One overarching goal  
18 of the Agency was to minimize their need for fall back  
19 plans. CMS wanted to have enough Medicare beneficiaries in  
20 each region to make it economically viable for two PDPs to  
21 enter each market. That logic might argue for lots of  
22 grouping of states into single regions, but after it spoke

1 with potential plans CMS decided that it would use a larger  
2 number of regions because stakeholders were concerned that  
3 they could be exposed to too much financial risk if regions  
4 included too many people.

5 CMS also tried to group states that had similar  
6 levels of average drug spending.

7 Let's talk a bit about the bidding process and how  
8 that will work. Risk-bearing plans are to submit bids to  
9 CMS by the first Monday in June, which this year is June 6.  
10 To submit a bid, plans will have to estimate what monthly  
11 costs of standard benefits and plan administration will be  
12 for a standard beneficiary. That means one of average  
13 health.

14 Here's the way that CMS will make payments to  
15 plans. Plans will get three types of prospective payments  
16 each month. They'll get paid their risk adjusted bid  
17 amounts, minus the premium that their enrollees pay. They  
18 will also get an estimated amount of individual reinsurance  
19 for very high cost enrollees who have drug spending above  
20 the catastrophic threshold. And they'll get low income  
21 subsidies for those plan enrollees who are in Part D's low  
22 income subsidy program.



1           After the end of the year, CMS and the plan will  
2 then have to reconcile those payments with actual  
3 enrollment, actual spending above the stop loss, and so on.  
4 As you can imagine, that process is going to be very  
5 complex.

6           Now let me describe how enrollee premiums will be  
7 set. First, CMS will take most of the bids from the risk-  
8 bearing plans and calculate a national average bid where the  
9 average is weighted by each plan's projected enrollment.  
10 Enrollees will have to pay a percentage of that nationwide  
11 average bid. But in addition, if their plan happened to bid  
12 more than the nationwide average the enrollee must also pay  
13 the full difference between the two. Likewise, if their  
14 plan bids under the nationwide average, the enrollee gets  
15 credited with the full difference between the two. This is  
16 the basic reason why we may see different levels of premiums  
17 under Part D.

18           This approach to setting premiums means that  
19 Medicare will basically pay the same direct premium subsidy  
20 for each enrollee with the caveat that it will be risk  
21 adjusted.

22           Under the MMA, CMS has the authority to adjust for

1 geographic differences in drug prices. But at least for  
2 2006, the Agency doesn't plan to make such an adjustment.  
3 Some analysts think that since many drug manufacturers,  
4 pharmacies and PBMs operate under national contracts,  
5 there's reason to believe that the underlying prices for the  
6 same drugs may not vary that much in different parts of the  
7 country.

8           The MMA does not allow for any kind of geographic  
9 adjustment related to differences in typical prescription  
10 drug use around the country. This means that people who  
11 live in parts of the country that tend to use more  
12 prescription drugs than average could pay higher Part D  
13 premiums than those who live in areas that use fewer  
14 prescription drugs.

15           Here is the same numerical example of premiums  
16 that I put into a text box that's in your mailing materials.  
17 Here we have three plans. Let's think of them as being in  
18 three different parts of the country. Look first at plan  
19 two. The yellow bar shows plan two's bid for the standard  
20 benefit and for a standard beneficiary. Notice that the  
21 bid, the yellow bar, is the same height as the dark line  
22 across the top. That line represents the national average

1 across all three of these bids. So when CMS does the math  
2 and calculates a base level enrollee premium from the  
3 national average of bids, it turns out that the enrollees in  
4 plan two just paid that base enrollee premium. That is why  
5 their pink bar, their enrollee premium, is the same height  
6 as the gray bar, the base enrollee premium.

7 Now look at plan one, which has a bid that's  
8 higher than the national average. In addition to the base  
9 enrollee premium, enrollees in that plan also would have to  
10 pay the full difference between the height of plan one's  
11 yellow bar and the thick white line on the slide. Notice  
12 that plan one's pink bar, it's enrollee premium, includes  
13 that full difference.

14 Similarly plan three has a bid that's lower than  
15 average. It's enrollee premium, the pink bar, is lower than  
16 the base enrollee premium by the same amount that plan  
17 three's bid is below the national average bid.

18 A key thing to take away here is that enrollee  
19 premiums across these three plans, the pink bars, could vary  
20 more in percentage terms than the plan bids, the yellow  
21 bars. That's because most enrollee premiums include the  
22 full difference between plan bids and the national average

1 added to a base enrollee premium that's relatively smaller  
2 because it's subsidized.

3           Publicly available data suggests that there is  
4 geographic variation in drug spending but patterns in that  
5 variation depend on the data source you use. This slide  
6 divides the country into four areas. Each bar reflects a  
7 different data set. Let me warn you that each of these data  
8 sets is a little different from the others in the years that  
9 it covers or the age of the populations that are covered.  
10 So the bars are indexes where the overall average of per  
11 capita drug spending in each data set has a value of 1.0.

12           Although they each show some geographic variation,  
13 the data sets don't tell precisely the same story. They  
14 generally suggest that drug spending is a little higher than  
15 average in the South and lower than average in the West.  
16 But one data set tells us that people in the Northeast have  
17 the highest spending per person while other data sets  
18 suggest the people in the Midwest or South have higher  
19 spending.

20           There is no gold standard among data sets for  
21 telling us how much geographic variation in drug spending we  
22 should expect to see for the Medicare population and for

1 Part D. In your mailing materials I talk about some of the  
2 problems with using available data to look at Medicare  
3 beneficiaries. But a key point here is that plans are also  
4 going to have a hard time estimating what their Part D  
5 spending will look like and therefore what their bids should  
6 be. It may take a few years of collecting real claims  
7 information to reduce uncertainty in setting premiums.

8 This work starts to explore the degree to which  
9 drug spending varies around the country. We intend for this  
10 research to help us think about how Part D premiums may vary  
11 geographically and help us to examine an issue that the  
12 Commission might want to monitor. But it also raises some  
13 other issues.

14 For example, will beneficiaries who live in some  
15 of the higher cost regions be less likely to enroll because  
16 their premiums will be higher? On the one hand, it may seem  
17 like a relatively high expense. But on the other hand,  
18 maybe people in those areas value prescription drug spending  
19 more and would be willing to sign up anyway.

20 A related issue is how plans will perceive the  
21 situation. If it looks like relatively high enrollee  
22 premiums in some parts of the country will affect take up

1 rates, will risk plans be less inclined to enter those  
2 markets? It will be interesting to see what effects  
3 geographic variation in Part D premiums have over time. For  
4 example, some analysts believe that within a given region  
5 competition among plans that is based at least in part on  
6 the price of the premiums could encourage higher cost plans  
7 to apply some of the management tools of their competitors  
8 and lower their costs. It's less clear, though, what  
9 effects would result from having different levels of  
10 premiums across geographic regions.

11 Of course, how you think about these and other  
12 issues related to geographic variation in drug spending  
13 depends on what you think is equitable. Some people believe  
14 it is more equitable for beneficiaries everywhere to pay the  
15 same amount, while others believe it is more equitable for  
16 Medicare to pay the same subsidy per beneficiary.

17 That concludes my presentation and I'm happy to  
18 take your questions.

19 MR. BERTKO: Rachel, could you go back to the bar  
20 graph with all that data on it. I would just make a comment  
21 that Bill and I observed in our other panel, the Trustees  
22 panel report. I believe you have the FEHBP data on their in

1 the middle bar, which I'll let you call it, but I think it's  
2 the pink one.

3 DR. SCHMIDT: Yes.

4 MR. BERTKO: There are, as you pointed out, lots  
5 and lots of limitations on the data quality here. I would  
6 suggest, partly from our discussions but also from other  
7 stuff, that this federal retirees and spouses from the FEHBP  
8 program may be the best we have in terms of going across  
9 regions.

10 Is this simply the BCBSA part of the data?

11 DR. SCHMIDT: That's what they refer to on the CMS  
12 web site.

13 DR. BERTKO: And so, in this sense, if you're  
14 trying to compare these across there, this might be the best  
15 one across because it's got similar kinds of people across  
16 regions. And as one of the other points then that to make  
17 is out of the amounts of variation there I think you'd note  
18 that maybe this one has the least -- among the lesser  
19 amounts of variation on there if you're just trying to  
20 observe something. That would be the first point.

21 A second point, and this is to address your  
22 comment about both competition, both in the region and

1 across regions, already there have been announced a couple  
2 of insurance carriers who say that they may be national  
3 players, that is offered in every state, thus bringing those  
4 utilization management tools across all.

5 First of all, I will again completely agree with  
6 you that we don't know enough about this. But the second  
7 part, the competition in these national players, may very  
8 well serve to reduce the current differences that might be  
9 observed in a graph like this. But again, we won't know  
10 until sometime late in 2006 how this all plays out.

11 DR. REISCHAUER: When we were discussing this  
12 yesterday, we didn't know the answer to the question on  
13 whether the national plan has to have a single premium  
14 across the country or can it go region by region?

15 DR. BERTKO: My understanding would be the bidding  
16 would be regionally but the plan is --

17 DR. REISCHAUER: But the plan's dimensions would  
18 be national.

19 DR. BERTKO: Yes. It's likely the formulary would  
20 be the same. It's very likely the drug utilization  
21 management would all be the same.

22 MR. HACKBARTH: Other questions, comments on Part



1 D premiums?

2 You were so clear, Rachel. No questions left  
3 unanswered. Thank you very much.

4 Next, we'll move to Medicare Advantage premium  
5 setting.

6 DR. HARRISON: Now let us discuss how MMA changes  
7 in the method for paying plans, particularly the  
8 introduction of bidding, might raise issues in our previous  
9 support for Medicare's financial neutrality.

10 MS. THOMAS: This is about halfway through your  
11 Medicare Advantage package.

12 DR. HARRISON: The Commission has supported the  
13 concept that private plans can offer beneficiaries an  
14 important choice of health care delivery systems. At the  
15 same time, beneficiaries' choice of delivery systems should  
16 not be influenced by differing levels of Medicare payment,  
17 depending on which choice the beneficiary makes.

18 MR. HACKBARTH: It's page 11, to help people find  
19 it.

20 DR. HARRISON: We have stated that the Medicare  
21 program should be financially neutral in the beneficiaries'  
22 choice. In other words, the Medicare program should spend

1 the same for a beneficiary who chooses any private plan as  
2 it would spend for that beneficiary to remain in fee-for-  
3 service Medicare. If payments for all beneficiary choices  
4 were equal in the local area, then competition for  
5 enrollment among the plans and between plans in fee-for-  
6 service Medicare would be based on the efficiency of each  
7 delivery system and the perceived quality of care they  
8 provide. Hopefully, this competition would result in  
9 increased efficiency and quality for Medicare services in  
10 the long run.

11 Under current conditions, paying the private plans  
12 at the same level as local fee-for-service spending would  
13 result in savings to the Medicare program. And I'll get  
14 into that a little more shortly.

15 We have made formal recommendations regarding  
16 financial neutrality in our past reports. In 2001 we  
17 recommended that Congress pay plans at risk adjusted rates  
18 similar to the cost those beneficiaries would have in fee-  
19 for-service Medicare. And we made a more precise  
20 recommendation in our 2002 report, recommending that  
21 Medicare+Choice payment rates should be set equal to risk  
22 adjusted local spending under fee-for-service Medicare.

1           When we made that recommendation there were some  
2 concerns about the adequacy of the risk adjustment mechanism  
3 and Dan will now talk briefly about the state of risk  
4 adjustment.

5           DR. ZABINSKI: Actually, what I'm going to discuss  
6 is quality of the risk adjustment that we have right now.

7           As part of the larger study mandated by the MMA,  
8 MedPAC is required to assess the predictive accuracy of the  
9 CMS-HCC risk adjustment model, which is current used to risk  
10 adjust payments for Medicare Advantage plans. This model  
11 uses administrative data, as well as beneficiaries'  
12 conditions diagnosed in the previous year to predict their  
13 costliness in the current year.

14           The analysis we performed consists of grouping  
15 beneficiaries by indicators of health status, including  
16 diseases diagnosed, program spending, and number of  
17 inpatient stays in the previous year.

18           DR. MILLER: Dan, since we've changed some of the  
19 order around, can you just be sure to point everybody to  
20 which hand out you're looking at?

21           MS. THOMAS: We added these. These were added, so  
22 you don't have them in your handouts.

1 DR. MILLER: In each instance, if you can make  
2 sure they know where they are.

3 DR. ZABINSKI: For each of those groups we  
4 compared predictive ratios from the CMS-HCC to predict the  
5 ratios from a model that uses only beneficiaries' age and  
6 sex to predict costliness. Where a predictive ratio is  
7 simply the mean of a group's costs as predicted by a risk  
8 adjustment model divided by the mean of their actual cost.  
9 The age/sex model that we used has been used in several  
10 studies as a point of comparison for other risk adjustment  
11 models. It is similar to the demographic model that CMS  
12 currently uses to adjust 50 percent of Medicare Advantage  
13 payments.

14 In our analysis we found that in each group that  
15 the predictive ratios from the CMS-HCC are closer to one  
16 than are the predictive ratios from the age/sex model. What  
17 that indicates is that the CMS-HCC does a better job than  
18 the age/sex model.

19 For example, on this diagram we divided  
20 beneficiaries by conditions diagnosed in the year 2001 and  
21 compared it to their costs for 2002. And as you can see for  
22 each condition, the predictive ratio is closer to one and

1 generally much closer to one under the CMS-HCC than under  
2 age/sex model. And as I just mentioned, that means the CMS-  
3 HCC is doing a better job of predicting costs.

4 I'll turn it back over to Scott and he'll  
5 complete the presentation.

6 DR. HARRISON: So I think we must now be on slide  
7 13. Mine, of course, are numbered differently.

8 The system used to pay Medicare Advantage plans  
9 this year is not financially neutral. Plans are paid based  
10 on administratively set county rates. However, the formulas  
11 that have set the rates are only partially based on county  
12 fee-for-service costs. While the formulas ensure that plan  
13 payment rates will not be lower than fee-for-service costs,  
14 rates are often well above the local fee-for-service.

15 Our analysis of the 2005 payment rates finds that  
16 they average 107 percent of fee-for-service currently. Some  
17 in the industry would disagree with some of the  
18 calculations, but even if we accepted their arguments the  
19 average would still be 105 percent.

20 The rates are above fee-for-service for two  
21 primary reasons. First, Congress wanted to encourage plans  
22 to go to low payment areas, so it guaranteed that no county

1 would have payment rates below the so-called floor rates.  
2 In many areas, the floor rate was well above the county's  
3 fee-for-service Medicare cost.

4           The second reason is the treatment of indirect  
5 medical education or IME payments. When a fee-for-service  
6 Medicare patient is treated in a teaching hospital, the DRG  
7 payment to the hospital includes an extra amount for medical  
8 education. Recall that I said plan payment rates are not  
9 allowed to fall below fee-for-service costs. Well, the  
10 measure of fee-for-service costs used to support the payment  
11 rates includes the fee-for-service IME payments.

12           The problem is that when a Medicare Advantage  
13 enrollee is treated in a teaching hospital, the plan pays  
14 the hospital a negotiated rate. And in addition, the  
15 Medicare program makes a payment to the hospital equal to  
16 what the IME payment would have been if the beneficiary had  
17 been in fee-for-service.

18           Thus, the Medicare program pays the plans the  
19 rates that include the expected cost of IME payments and  
20 also pays those same amounts directly to the hospital.

21           We have prepared a draft recommendation on IME for  
22 you to consider at the end of this. As the recommendation

1 is currently stated, the Congress could follow it by either  
2 removing expected IME payments from the measure of fee-for-  
3 service costs or by discontinuing IME payments to hospitals  
4 on behalf of Medicare Advantage patients. In your  
5 discussion later you might consider whether one of these  
6 actions is preferable to the other.

7 MR. HACKBARTH: Scott, let me just leap in for a  
8 second and clarify for the audience that we will be taking  
9 no votes at this meeting. All votes on recommendations will  
10 occur at the April meeting.

11 DR. HARRISON: The current system that I just  
12 talked about ends this year and next year a bidding process  
13 will determine Medicare's payments to plans. However, the  
14 current payment rates are still used in the process. Under  
15 the new process, plans will submit a formal set of bids to  
16 participate in Medicare Advantage. Each bid will consist of  
17 up to three separate components. However, the payments are  
18 based on only one component, which is the bid for the  
19 standard Medicare Parts A and B benefits. For this  
20 presentation the term bid will mean the A/B bid.

21 Payments to the plans are determined by the plan's  
22 bid and the payment area's benchmark. The benchmarks for

1 2006 are the 2005 county payment rates updated by a national  
2 growth rate. A plan's bid will be compared with the  
3 benchmark. If the bid is below the benchmark, the plan is  
4 paid its bid plus 75 percent of the difference, known as the  
5 savings -- I'm sorry, the difference is known as the  
6 savings. So 75 percent of the savings go to the plan. And  
7 the remaining 25 percent of the savings is retained by  
8 Medicare. The plan is then obligated to return its share of  
9 the savings, and that's called the rebate, to its members in  
10 the form of supplemental benefits or reduced cost sharing or  
11 a reduction in premiums.

12           If for some reason a plan bids higher than the  
13 benchmark, the plan is paid just the benchmark and the plan  
14 enrollees would have to make up the difference with a  
15 premium.

16           This process probably will not produce financially  
17 neutral payments as I'll show in the following example of  
18 how the plan bids will affect Medicare payments to plans as  
19 well as beneficiary premiums.

20           For this example, let's assume the national Part B  
21 premium which all beneficiaries, even plan members, are  
22 responsible for paying, is \$100 per month. And we are in a



1 county with average fee-for-service costs of \$1,000 a month.  
2 Just for illustration purposes I assumed that the benchmark  
3 was also \$1,000, even though I know benchmarks are likely to  
4 be above fee-for-service costs.

5 Two plans bid here, one at \$950 and the other at  
6 \$900. Beneficiaries in fee-for-service Medicare are  
7 unaffected by the bidding process and they continue to pay  
8 the Part B premium.

9 Now let's look at plan two, and we'll look at two  
10 because the math is easier. Plan two bids \$100 below the  
11 benchmark so it is paid its bid of \$900 plus 75 percent of  
12 the \$100 difference for a total of \$975. The enrollees in  
13 plan two will receive a reduction in their premium of the  
14 \$75 rebate because for the illustration here I have assumed  
15 that the rebate would all be returned to the beneficiary in  
16 the form of a premium reduction. As a result, plan two  
17 enrollees would pay an adjusted premium of \$25 for the  
18 Medicare package of benefits.

19 Sparing you the math, plan one would receive  
20 payments from the Medicare program of \$987.50 and its  
21 enrollees would pay an adjusted premium of \$62.50.

22 Because part of the difference between the bid and

1 the benchmark is retained by the Medicare program, plans may  
2 receive different payments than each other as in this  
3 example and payments different than Medicare's cost for  
4 covering beneficiaries in fee-for-service.

5           Of course, I should note that currently benchmarks  
6 are above fee-for-service Medicare costs and some plans will  
7 likely receive payments higher than fee-for-service costs.  
8 But this example illustrates that the bidding process is not  
9 financially neutral even when the benchmark is lowered to be  
10 equal to the fee-for-service Medicare cost.

11           This shows that we can't get financially neutral  
12 payments from a bidding process where a plan's bid  
13 determines its payment unless we restate our financially  
14 neutral recommendation to say that plan's should be paid no  
15 more than local fee-for-service costs rather than equal to  
16 fee-for-service costs. However, if we set the benchmarks at  
17 100 percent of local fee-for-service costs and redistribute  
18 Medicare's share of the savings back to the plans in the  
19 form of quality payments, we would have a financially  
20 neutral system that would not discourage plan participation  
21 in enrollment by reducing payments below fee-for-service.  
22 And we might further encourage quality in the plans.

1           It is also possible to create a bidding system  
2 that is financially neutral another way. We have created  
3 one here to illustrate some of the potential implications of  
4 such a system. Under this illustrative full competition  
5 system, plans would submit bids. The fee-for-service system  
6 would also be considered a plan and its bid would be  
7 considered to be the area's fee-for-service cost.

8           The area's benchmark would be the average of all  
9 bids, including the fee-for-service system. And all plans  
10 would be paid at the benchmark. Beneficiaries enrolling in  
11 plans with bids above the benchmark pay a premium equal to  
12 the difference. And beneficiaries enrolling in plans with  
13 bids below the benchmark would receive a rebate equal to the  
14 full difference between the benchmark and the bid.

15           So here we are again in a county with average fee-  
16 for-service costs of \$1,000 and two plans bidding \$950 and  
17 \$900 respectively. For this example, let's assume a  
18 benchmark of \$982.50.

19           Under this illustrative system, beneficiaries in  
20 the fee-for-service Medicare system in the market would pay  
21 an extra \$17.50 above the usual Part B premium. Meanwhile,  
22 enrollees in plan two would receive a rebate of \$82.50. The

1 Medicare program would make the same financially neutral  
2 payment equal to the benchmark on behalf of each beneficiary  
3 regardless of the beneficiary's choice of plan.

4 Beneficiaries, on the other hand, would face the full cost  
5 difference in their enrollment decision shown here as \$100  
6 difference in premium between fee-for-service Medicare and  
7 plan two which bid \$100 less than the fee-for-service cost.

8           In addition to advocating a payment policy that  
9 supports risk adjusted financial neutrality for all types of  
10 plans, we recognize that there may be other considerations  
11 that should affect payment policy design. We recognize that  
12 some policymakers have increased plan participation as a  
13 goal. We also recognize that some policymakers are  
14 concerned about the geographic variation in the Medicare  
15 program and about the overall cost of the Medicare program  
16 and about protecting low income beneficiaries by providing  
17 low-cost options.

18           I'm using this chart to try and explain why  
19 Medicare has always had trouble attracting plans to many low  
20 cost areas, particularly rural parts of the country, and why  
21 plans have gravitated to the higher urban markets. The  
22 bottom axis shows the level of fee-for-service Medicare

1 costs in a local market. The height along the side axis  
2 shows the cost of delivering the Medicare benefit package in  
3 the local area, either by the fee-for-service program  
4 represented by the dotted orange line, or by private plans  
5 represented by the solid red line.

6 The chart illustrates our hypothesis of the  
7 relationship between managed-care plan costs and fee-for-  
8 service costs. The thought is that plans have some fixed  
9 administrative costs and can reduce costs from fee-for-  
10 service levels by managing care more efficiently and/or by  
11 reducing payment rates paid to providers. Regardless of the  
12 technique that the plan uses, they can reduce spending more  
13 where there are higher levels of fee-for-service spending.

14 Our quantitative analysis confirmed the general  
15 shape of this relationship and our analysis suggests that  
16 the initial costs to administer plan systems can best be  
17 offset in higher cost areas or in areas where they can  
18 attract large membership. In many low cost areas plans are  
19 likely to have higher total costs than fee-for-service  
20 Medicare.

21 This may help explain why managed care plans were  
22 not attracted to many lower cost areas even when legislation

1 raised payments in those areas.

2           Financially neutral payment systems are unlikely  
3 to attract plans to low cost areas because really the only  
4 way to attract plans to those areas is to pay more than the  
5 cost of fee-for-service there.

6           However, in areas where plans have been able to  
7 compete successfully with fee-for-service Medicare, plan  
8 participation would be likely to increase under this  
9 illustrative competition system. In these areas,  
10 beneficiaries would have to pay higher premiums to stay in  
11 fee-for-service Medicare and some beneficiaries are likely  
12 to switch to private plans to avoid these higher premiums.  
13 Therefore, plans are likely to enter these higher payment  
14 areas to meet the increased demand for low premium options.

15           This table shows what might happen under the  
16 illustrative competition model in three different types of  
17 areas and serves to illustrate some of the competing views  
18 of geographic equity that we might wish to consider. Area  
19 one is a low-cost area that does not have any private plans.  
20 Area two is a medium cost area with some private plans that  
21 are competitive with fee-for-service Medicare. And area  
22 three is a high cost area with plans that are much less

1 costly than fee-for-service Medicare.

2           The first column shows the fee-for-service costs  
3 in each area and illustrates one view of geographic equity  
4 or inequity that beneficiaries in different parts of the  
5 country have different amounts spent on them under fee-for-  
6 service Medicare. Plans in those areas are also currently  
7 paid different amounts, often reflecting those differences.  
8 Currently, however, beneficiaries in all three areas can  
9 participate in fee-for-service Medicare for the same Part B  
10 premium.

11           The second column shows the benchmark that results  
12 from bidding under this illustrative system. Because the  
13 benchmark is the average bid in the area, it is guaranteed  
14 there will be at least one option available in each area  
15 that bid at or below the benchmark, meaning that there would  
16 be at least one option available at or below the premium  
17 benchmark, the benchmark premium which is \$100 in this case.

18           MS. BURKE: I'm sorry, would you step back two  
19 steps and say that again? I'm trying to figure out -- is  
20 the benchmark here the average of the three where the  
21 benchmark is the fee-for-service in the first but not in the  
22 second?

1 DR. HARRISON: The benchmarks are area specific.  
2 They are calculated, created, whatever as an average of the  
3 bids in those areas.

4 MS. BURKE: The bids, including fee-for-service.

5 DR. HARRISON: Including fee-for-service.

6 MS. BURKE: I got it.

7 DR. MILLER: So the reason it equals in the first  
8 area is because there's no plan to bid it down; right?

9 DR. HARRISON: Right.

10 In fact, that was my next sentence.

11 The Medicare program pays the benchmark to all  
12 options in each market so that Medicare would continue to  
13 pay more in area three but the difference in payments  
14 between markets would decrease from the current situation.

15 The fee-for-service premium is equal to \$100 plus  
16 the difference between the fee-for-service costs and the  
17 benchmark in each market. For example, in area two the fee-  
18 for-service premium would be \$100 plus the \$10 difference  
19 between the \$800 fee-for-service costs and the \$790  
20 benchmark. Looking down that column, you will notice that  
21 the fee-for-service premium can vary significantly with  
22 beneficiaries in area one paying \$100 and beneficiaries in



1 area three paying \$200. This difference in premium for fee-  
2 for-service Medicare may be viewed as an inequitable by  
3 some. And bear in mind this is the type of system that we  
4 are going to have for the setting of Part D premiums.

5 The last column, however, shows that beneficiaries  
6 in all markets can get the Medicare benefit package  
7 delivered by a choice. One option that bid at the benchmark  
8 for the same \$100 across the country. Only in area one  
9 would that the benefit package be delivered through the fee-  
10 for-service Medicare system. In areas two and three,  
11 beneficiaries would have to pick a plan that had bid at or  
12 below the benchmark in order to pay the \$100 or lower  
13 premium.

14 Now let me just quickly summarize what I've talked  
15 about about financial neutrality.

16 DR. MILLER: Scott, why don't you back up to that  
17 slide just for a second to make sure that we have everybody.

18 What's going on here is that if you stayed in fee-  
19 for-service you would either pay \$100 in area one or area  
20 two you would pay \$110. That \$10 is arrived at -- the \$100  
21 everybody pays. The \$10 difference is the difference  
22 between \$790 and \$800. What the last column is saying is

1 that plans in an area who underbid the benchmark can still  
2 deliver the benefit at \$100.

3 So what this illustrates is two things. Number  
4 one, if you choose to stay in fee-for-service in this  
5 illustrative example, you would pay more out-of-pocket.  
6 Alternatively, you could get the A/B benefit by moving to a  
7 plan at \$100. That's the point of the illustration and how  
8 you can think about geographic equity in a couple of  
9 different ways.

10 MR. HACKBARTH: Everybody have that? This is an  
11 important basic foundation point. Any questions about it?

12 DR. BERTKO: Just to make a point that as an  
13 illustration of how Part D works with the wrong number of  
14 zeros, it's accurate, and but it does not exist in law  
15 today.

16 MR. HACKBARTH: Explain that, John.

17 DR. BERTKO: The illustration is good but this is  
18 not how the MMA works today. This is just an illustration  
19 of a fully competitive system and we today, on the A/B  
20 benefits have, for lack of a better term, a semi-competitive  
21 system.

22 DR. MILLER: That's absolutely correct. We're

1 trying to just illustrate how a pure competitive model might  
2 work across geographic areas to illustrate these two  
3 different points about how a beneficiary could choose, on  
4 the one hand to pay more out-of-pocket, or alternatively  
5 move to a plan. This does not exist under MMA. This is a  
6 different way of thinking about how to pay plans. That's  
7 correct.

8 MS. BURKE: Is the presumption that the fee-for-  
9 service premium is still calculated on a 25/75 basis? So  
10 that -- in terms of the program's costs.

11 DR. HARRISON: Yes, it's just fixed across the  
12 country.

13 MS. BURKE: It's just fixed. So query how that  
14 relationship changes, I mean what the general revenue  
15 contribution becomes over time, what that ratio looks like.

16 MR. HACKBARTH: But that's an independent variable  
17 that could be altered by different forces.

18 MS. BURKE: I understand. I'm just trying to  
19 understand politically when you go down this road what does  
20 it mean about the ratios, what the general revenue  
21 expectations is in terms of the support of the program going  
22 forward, how that begins to alter.

1 MR. HACKBARTH: So if I'm following, there's  
2 always a reaction to the action. So if such a system were  
3 in place and it meant substantial increases in premiums to  
4 stay in traditional fee-for-service in some markets, another  
5 variable that the political process might turn to is the  
6 25/75 split.

7 MS. BURKE: Right. And the basis upon which it's  
8 calculated, which would change.

9 MS. RAPHAEL: Just a point of information. This,  
10 I assume, is predicated on having a full risk adjuster?

11 DR. HARRISON: Yes.

12 MR. HACKBARTH: So these numbers are all caring  
13 for the same level risk person and equal level of risk  
14 assumed.

15 MS. RAPHAEL: That we don't have a different  
16 population in fee-for-service.

17 DR. REISCHAUER: You said that you can get the  
18 Medicare A/B benefit package for paying the same premium.  
19 But I mean, in all these examples, you could get it for even  
20 less; right?

21 DR. HARRISON: Most likely you'd have some bids  
22 below the benchmark, yes. In area one, you wouldn't --

1 DR. REISCHAUER: I mean, you'd have to have some  
2 below the benchmark, arithmetically.

3 DR. HARRISON: It would depend on how you actually  
4 set that average.

5 MR. HACKBARTH: Let me just go back to Carol's  
6 question about risk adjustment. That really explains why we  
7 had Dan's presentation on the risk adjustment system  
8 inserted in here.

9 When MedPAC last looked at this issue of  
10 competitive bidding for private plans we said that it has  
11 positive attributes but also some areas of concern. One is  
12 on the impact on beneficiaries that remain in fee-for-  
13 service. In particular related to that is if you don't have  
14 a good risk adjustment system and there's adverse selection  
15 against the traditional fee-for-service program the premiums  
16 for staying in that option could spiral dramatically.

17 So this was March 2001 when we were still using a  
18 demographic based model. As Dan described in his  
19 presentation, the new risk adjustment system is quite  
20 significantly better than the old demographic model. So  
21 that raises the question well, is that enough of an  
22 improvement to offer a more stable competition, a fairer

1 competition between traditional fee-for-service and private  
2 plans?

3 Other questions or comments on this?

4 MS. DePARLE: Are you done, Scott?

5 DR. HARRISON: I was just going to summarize. I'd  
6 just as soon not interrupt the flow of the conversation.

7 MS. DePARLE: So John just made the point that  
8 this isn't what the law is but chart 15, I think, is the one  
9 that reflects current law under the MMA?

10 DR. HARRISON: I'm not sure what your numbers are.

11 MS. DePARLE: Just to follow through on one of the  
12 points you made --

13 MR. HACKBARTH: Yes, that's right. Page 15 is the  
14 description of current law under MMA.

15 MS. DePARLE: I just want to understand one point  
16 that Scott made. You make the point, Scott, on plan number  
17 two that you've treated the premium adjustment as though it  
18 were being fully given back to beneficiaries. In fact,  
19 isn't it the case that the plan could be getting a payment  
20 of \$975 plus \$75? There's nothing in the law that requires  
21 them to give it all back is there?

22 DR. HARRISON: Yes, there is something in the law

1 that requires them to give it back. The reason I made that  
2 assumption, what really I would expect to happen is that the  
3 plan would take this \$975 and provide a package probably  
4 richer than the Medicare benefit package and either give  
5 some premium rebate to the beneficiaries or not.

6 MS. DePARLE: The thing that would enforce that  
7 which hasn't been there before is what?

8 DR. BERTKO: The law.

9 MS. DePARLE: The law has said that before, too.  
10 So what is the mechanism?

11 DR. HARRISON: It's the bidding process. The  
12 bidding processes says you're going to submit a bid for the  
13 basic benefit package, a second component for any  
14 supplemental including lower cost sharing. And then the  
15 third would be for the Part D but I didn't want to confuse  
16 us with the Part D.

17 MS. DePARLE: But the idea is supposed to be that  
18 CMS and the actuaries will have more time and more energy  
19 devoted to assessing this to make sure that the savings are  
20 really returned both to the program and the beneficiaries?

21 DR. HARRISON: Yes.

22 DR. BERTKO: I'll make one comment now and maybe a

1 couple later. On this slide, in particular, let me point  
2 out here that if the benchmark were actually the fee-for-  
3 service prong exactly --

4 DR. HARRISON: Which it is here.

5 DR. BERTKO: Yes, which it is here, that the  
6 payments here, because of the competition to plans, will  
7 actually turn out to be under the fee-for-service benchmark  
8 because of the recapture of the 25 percent, namely \$12.50  
9 from plan one and \$25 from plan two.

10 Scott made a comment here that this could be  
11 recycled. That, again, is not in law either.

12 MR. HACKBARTH: I want to come back to the  
13 recycling point in a minute but let's get some other  
14 comments on the table. Alan and then Dave. Was it on this  
15 particular point? Go ahead.

16 MR. SMITH: Scott, we could add to the chart on  
17 page 15 plan four or plan three, which bid at higher than  
18 the benchmark; right? The law would provide for an option  
19 which had a beneficiary choosing to pay a higher premium  
20 equal in the other direction?

21 DR. HARRISON: Yes.

22 MR. SMITH: And again, would be free to modify the



1 benefit package above the A/B combined in order to try to --

2 DR. HARRISON: Yes, but you need to charge an  
3 extra premium for the A/B part and then you need to charge  
4 the full additional premium for any supplemental package you  
5 offer.

6 MR. SMITH: So you couldn't take your higher  
7 premium and use that as the resources to underwrite a richer  
8 benefit package?

9 DR. ZABINSKI: And these bids are strictly for the  
10 A/B benefit package.

11 MR. SMITH: Strictly for what's paid for by the  
12 benchmark number?

13 DR. HARRISON: Right.

14 MR. SMITH: Thanks.

15 DR. NELSON: With respect to the subsequent slide  
16 to this, the one that shows the \$200 premium, I think it's  
17 on page 20 of what we've got. This model makes sense  
18 looking at it from the side of the payer who is trying to  
19 achieve some sort of neutral impartial treatment of the  
20 various delivery products. But from the standpoint of the  
21 beneficiary, it's patently unfair because the fee-for-  
22 service beneficiary in a high cost area gets whacked with a

1 higher premium even though it's the provider of care that  
2 orders the services that set the higher levels of  
3 utilization within the area.

4 DR. BERTKO: That's actually not necessarily true.

5 DR. NELSON: If I were a beneficiary in Florida  
6 and I got whacked a higher premium, I would argue that it's  
7 not my fault. I didn't do it. It's the practice style or  
8 whatever those causes are.

9 DR. REISCHAUER: You're a parsimonious user of  
10 services would be the argument. I'm not the average of  
11 Miami.

12 MR. HACKBARTH: Let me just amend that. There are  
13 two different ways basically, and a very simple way of  
14 thinking about this, is setting the benchmark. One is the  
15 national average benchmark, in which case if you live in a  
16 very high cost area as a beneficiary you could get nailed  
17 due to the practice patterns that prevail in your part of  
18 the country versus the national average.

19 Another model is to have the benchmarks based on  
20 local markets. In that case it wouldn't be the prevailing  
21 practice pattern in the community that results in your  
22 paying the higher premium because there are other lower cost

1 options available in that market. The logic would be that  
2 it's because you elected a relatively unconstrained open  
3 system, fee-for-service system, that is increasing your  
4 premium, not the prevailing practice pattern in the  
5 community.

6 So the model that we're talking about, at least as  
7 I see it, is the second model with locally set benchmarks  
8 which obviate the problem of getting whacked just because of  
9 the regional differences.

10 DR. CROSSON: I'd like to back off from the  
11 numbers for a minute and talk for a few minutes about the  
12 financial neutrality idea itself. It seems to me, just from  
13 this discussion, and I hope over the next month or so we  
14 have more discussion about what we actually mean by that and  
15 what values we're talking about and then some of the  
16 derivative consequences of picking one interpretation of  
17 financial neutrality or the other. I'd like to just talk  
18 about two things.

19 One, I think, was mentioned in the report and it  
20 has to do with the real life consequences of changing the  
21 payment system, changing the proposed basis for the  
22 benchmark on low income seniors. I think it's certainly

1 been our impression, in our own program, that a significant  
2 number of Medicare Advantage beneficiaries are low income  
3 seniors. I don't know what the proportion is but it's a  
4 fairly significant. And that, in fact, one value of the  
5 Medicare Advantage program as it currently set up, rightly  
6 or wrongly, is that it results in lower out-of-pocket costs  
7 to those same low income seniors.

8 Not that is a value. It's not the value of  
9 financial neutrality but it has a real life value.

10 I would hope, as we work this through, that we  
11 focus our analysis, at least in part, on that question  
12 because that's a very real world -- will be or could be a  
13 very real world consequence of changing.

14 The second one has to do with the fact that again  
15 -- and this is not to suggest that the way we've gotten here  
16 in terms of the payment structure was good or even  
17 thoughtfully constructed. But it seems to me, as I look at  
18 what the Congress is trying to do here, is that there's a  
19 suggestion that Medicare Advantage or private plans or  
20 whatever you want to call it has a potential value in the  
21 future.

22 Could we return to slide 12 for a second? If we

1 were to just change the basis for the -- no, your slide 12,  
2 I'm sorry.

3           If we were just to change the horizontal axis  
4 there and suggest that was time, I think there's a  
5 suggestion -- and this is something that I believe that in  
6 order to get to that world that some believe we could be in,  
7 which is that private plans, if you will, result in higher  
8 quality and lower cost through the inherent efficiencies of  
9 the private market and whatever. You may disagree with that  
10 but others believe that.

11           Then it would suggest that to fill in that area  
12 under the curve at the beginning of that line, there is the  
13 need for some investment.

14           I think that some believe that that investment is,  
15 in fact, what's intended even though, as I said, the way we  
16 got there may not have been a kind of sausage making that  
17 any of us would like to have seen.

18           So I just hope that as we go through this we take  
19 that into consideration and we kind of analyze the real  
20 world necessity, if you will, for an investment over a  
21 period of time and how that relates to the underlying value  
22 of financial neutrality. Because I think, again, if it's

1 true -- let's just take the pay for performance for the  
2 moment. Let's assume that we weren't under the constraints  
3 that we had in terms of the budget deficit and concerns  
4 about Medicare costs and we wanted to pursue pay for  
5 performance more aggressively, as some commissioners have  
6 argued.

7           We might have decided in a different environment  
8 that additional money needed to be put in there in order to  
9 aggressively move that forward. I think some proponents of  
10 the payment system as it exists and of potential ways that  
11 it could exist, their arguments are predicated on the idea  
12 that over some period of time investment is needed in order  
13 to get to that better world. Some may not agree with that  
14 but I think it's a legitimate issue.

15           MR. HACKBARTH: Let me go to your initial  
16 statement about we need to think through carefully the  
17 implications of neutrality. And that's the very purpose of  
18 this. There have been important changes in the rules of the  
19 game. And so I envision this as our thinking about what  
20 does, in fact, neutrality mean? That's abstract. Let's get  
21 more concrete and apply it to particular models and see  
22 whether we can come up and either endorse existing models

1 that are in MMA or refinements of them that get us closer to  
2 where we want to be, not just on neutrality but on a number  
3 of other goals.

4 My personal list is I'd like to have a system  
5 that's neutral. I would like to encourage participation by  
6 plans so that beneficiaries have more options. I would like  
7 to have a system that better matches payments to cost than  
8 pure administered prices systems do. This is the standard  
9 MedPAC thinking. Let's try to get our payments so that they  
10 better reflect the costs of high quality, risk adjusted  
11 care.

12 I'd like a system that also helps reduce federal  
13 expenditures given the pressing problems that the program  
14 faces and a pure administered price system does not do that.  
15 The money goes back to the plans and beneficiaries  
16 exclusively.

17 And I'd like to reward quality. Those are all  
18 goals that I have. And how we achieve them is the trick.

19 I would also endorse what you say about making  
20 sure that we protect low income beneficiaries. And with  
21 some modification, I could even agree to encouraging  
22 investment in good things.

1           My concern about the existing policies on those  
2 two points is that they are indiscriminate. The extra  
3 dollars do not just go to support care for low income  
4 beneficiaries. And the dollars do not just flow to  
5 organizations investing in improving care. They are just  
6 spewed out in every direction. But I think that those are  
7 also important values.

8           So where I had hoped that this conversation might  
9 go, and then I'll let you folks take over, is that we try to  
10 match up where we are and MMA as the system will work in  
11 2006 with goals like that and see if we can suggest ways  
12 that the system might be tweaked, amended so that it will  
13 move us more closely towards maximizing those kinds of  
14 values.

15           DR. MILSTEIN: Given the goals that Glenn  
16 outlined, I would hope that our future analyses and  
17 discussions might also begin to look at benchmarks that  
18 include disaggregated performance units within Medicare fee-  
19 for-service. More recent publications from the Dartmouth  
20 research team are beginning to tell us a couple of things,  
21 including the fact that by and large Medicare patients in  
22 the fee-for-service program tend to stay loyal to a



1 particular hospital and their associated medical staff.

2           Everything I'm saying now is pertinent to urban  
3 areas -- I'm not talking about rural areas -- where by and  
4 large beneficiaries do have pretty good choice and ability  
5 to shop among hospitals and their affiliated medical staffs.

6  
7           And so what the more recent Dartmouth research is  
8 telling us is that within urban areas hospitals and their  
9 affiliated medical staffs in the Medicare fee-for-service  
10 program vary dramatically with respect to total resources  
11 consumed, and in some cases quality of care.

12           So I hope that as we begin to explore various  
13 frames of reference for deciding what really constitutes  
14 benchmark performance in a geography, we don't limit our  
15 evaluation of the fee-for-service program to all hospitals  
16 and all doctors in a geography as a lump, but rather begin  
17 to build on some of the analytic insights coming out of the  
18 Dartmouth group and begin to, in urban areas, look at  
19 hospitals and their affiliated medical staffs as one source  
20 of fee-for-service benchmark.

21           DR. SCANLON: To echo Jay's comment about the need  
22 to define what we mean by neutrality. And part of it is

1 reinforced by what you said in terms of the list of  
2 objectives that you have, and I wouldn't disagree with them  
3 in most senses of them.

4           But for me they almost come ahead of the issue of  
5 neutrality. I'm not only concerned about having -- or  
6 primarily concerned about having Medicare neutral in terms  
7 of how it pays, but having Medicare be efficient, buying  
8 quality, encouraging a change in the system that makes it  
9 more sustainable over time. Those are kinds of things that  
10 take preeminence.

11           Then the question is if I think of them as my  
12 primary goals and I want to think about how I use plans and  
13 the fee-for-service system to achieve those goals, how would  
14 I define neutrality when I'm done thinking about those prior  
15 questions. I think it may be different than where we are  
16 today in terms of this discussion because this discussion is  
17 assuming they we're bidding on a Part A and a Part B benefit  
18 by all these different plans and it's all the same. I think  
19 potentially it's not.

20           What Arnie just said about trying to influence the  
21 choices of providers. It's different, what plans are trying  
22 to do versus what the fee-for-service system tries to do.

1 We may want to reward that difference.

2 We may think that we don't want to over reward it,  
3 and maybe neutrality is defined in that sense, that we don't  
4 sort of pay more for this management than we should.

5 I'd like to go down the path of the objectives  
6 that you have and think about how we would structure use of  
7 private plans in Medicare and in their relationship to fee-  
8 for-service and develop sort of the definition or we think  
9 about neutrality or how the word neutrality fits into that  
10 context after we've done that, as opposed to starting with  
11 it and thinking that we can look at the current system and  
12 say we can revise it to be more neutral. Because these  
13 other objectives are more critical in my mind.

14 The other thing I think that's important, and Jay  
15 brought it up to an extent, is this issue of there are  
16 people that believe that we are making an investment and  
17 we're going to get plans to participate and we're going to  
18 see the benefits of that, the beneficiaries are going to see  
19 the benefits of that, and we're going to transform the  
20 system with that respect.

21 It's, I think, important to test some of these  
22 ideas including what you brought up a little bit earlier

1 about risk adjustment. I'm not sure if the risk adjustment  
2 assessment that we've done is based upon enrollees in plans  
3 or is it based upon fee-for-service beneficiaries

4 DR. ZABINSKI: Fee-for-service only.

5 DR. SCANLON: The issue is going to be how good is  
6 that risk adjuster after we see who actually enrolls.  
7 Because that's the test that we used before. Clearly, it's  
8 doing better than the demographic model. But is it going to  
9 do well enough when we actually experience in the real  
10 world?

11 So we need more information and we need a broader  
12 context, I think, to have this discussion.

13 MR. MULLER: I think the themes of looking at how  
14 we get better care through long term effective management of  
15 care for the population is one that we've been suppressing  
16 all year.

17 My reading of the background that we had on the  
18 payment though in the material that was sent to us is that  
19 the payments, in fact, unlike the ones up on the screen,  
20 will be higher than the fee-for-service during this  
21 transition period.

22 I'm concerned that some of the evidence we saw in

1 Medicare+Choice seven or 10 years ago, where plans come in  
2 when the payments are better and exhibit pretty fast when  
3 the payments get reduced, as they seem inevitably to get  
4 reduced when there's budget crunches going on and so forth,  
5 that we not have a lot of people coming into this for short-  
6 term advantage, financial advantage and not for the long-  
7 term advantage of the beneficiaries.

8           Obviously, institutions such as Jays, that have  
9 been around for 50 years or more don't come in and out of  
10 this but others might. I think one of the things we need to  
11 be looking at is if the payment incentive is concerned  
12 enough about fee-for-service that, in fact, we are violating  
13 at least my understanding of payment neutrality that may  
14 encourage that kind of behavior rather than that kind of  
15 long-term behavior that Bill and others in the previous  
16 comments have asked for.

17           Because obviously if one thinks of investment and  
18 investing in the kind of case management and disease  
19 management and other kind of performance-enhancing measures  
20 that we all want to encourage, that requires a kind of  
21 constancy of approach to working with the population over a  
22 period of time.

1           That could be mitigated if, in fact, people come  
2 in and come out of this program once the financial advantage  
3 is not as great.

4           Therefore also, I think these examples, perhaps  
5 Scott and Dan could share some of the examples of not the  
6 competitive modeling in theory but what, in fact, we are  
7 paying right now, which is different than I take it we're  
8 showing on the sheets. I want to make sure I understand.

9           If the payments are above the fee-for-service plan  
10 where, in fact, does that extra go? Does it go necessarily  
11 to the beneficiary through enhanced services? To use this  
12 chart, let's say if we put \$1,100 in there, just for the  
13 heck of keeping in round \$100 numbers. How would roughly  
14 this chart read if it was an \$1,100 payment and the fee-for-  
15 service in this example were \$1,000? Where would the extra  
16 money go?

17           DR. HARRISON: On this chart, let's say you had a  
18 plan that -- I'm sorry, the benchmark was set at \$1,100.  
19 Let's look at plan two. Plan two would get \$900 plus 75  
20 percent of the \$200 different. So \$150. They'd get \$1,050.  
21 They would need to give back \$150 in benefits to the  
22 enrollee.

1 DR. BERTKO: Yes.

2 MR. MULLER: But they're not obligated to give  
3 \$150 in benefits back?

4 DR. BERTKO: Yes, they are. It's in the law.

5 MR. MULLER: Okay.

6 DR. MILLER: To just one other point that you were  
7 saying, at least in the 2006 bidding process you have the  
8 benchmarks that are set above fee-for-service. And then you  
9 have the requirement that 25 percent of the savings go back  
10 to the government. We're not saying definitively that the  
11 plans will be paid above fee-for-service. I don't think we  
12 know because we have to see how the bids come in.

13 It's just with the benchmark where it is and 25  
14 percent, between that arithmetic it's not exactly clear  
15 where we would end up paying.

16 DR. HARRISON: Yes, that's correct.

17 MR. SMITH: Thanks Glenn. Arnie and Bill and  
18 Ralph have raised a lot of what I wanted to, but three  
19 thoughts.

20 Jay, you talked about changing the horizontal axis  
21 on the chart on page 18 to a time axis. When Scott  
22 described what might explain this changing production

1 function, he offered two hypotheses. Neither was time. One  
2 was volume and one was the cost of providing services in an  
3 area. A high-cost high-volume area would show the dotted  
4 line exceeding the solid line sooner.

5 In our experience, as Ralph described, with time  
6 and Medicare+Choice is we got less of it over time, not that  
7 we got more of it. Not only did we get less participation  
8 but we got less services provided as plans cut those over  
9 time. So we ought to be careful hypothesizing that time  
10 here produces more investment and higher quality.

11 I'm concerned, too, Glenn, and I don't fully know  
12 how to think about this. A lot of the discussion has been  
13 helpful. But I suspect, as Bill argued, we need months of  
14 it, not hours of it.

15 When we started to talk about neutrality we had  
16 two notions in mind. It is interesting that the word choice  
17 has slipped out of the vocabulary here. We had a neutrality  
18 notion with respect to choice, that if Bill chose to  
19 participate in the fee-for-service system or chose to  
20 participate in a managed-care plan that his choice ought to  
21 be neutral with respect to the impact on him financially.

22 Now we've reduced the neutrality notion simply to



1 a taxpayer notion, that taxpayers ought to be indifferent as  
2 to what choice Bill makes. It's a huge difference,  
3 obviously, between a \$100 premium and a \$200 premium with no  
4 assurance at all that if I make the rational financial  
5 choice I'm actually getting the same service or the same  
6 quality of service -- Arnie's question -- that I'd be  
7 getting if I made the \$200 choice. And no assurance at all,  
8 and in fact some reason to be quite suspicious, that making  
9 the financially sensible choice is something which will meet  
10 my long-term needs for stable care and a stable situation  
11 with continuity of providers because our experience is, the  
12 last time he went down this route, that didn't happen.

13           This is both more complex in vocabulary terms, but  
14 I do find it interesting that we've now reduced neutrality  
15 to only one of the two dimensions that we thought was  
16 important 24 months ago.

17           MR. HACKBARTH: I think you've given a very  
18 concise clear summary of some of the most important concerns  
19 of those people who argue against the pure competitive  
20 bidding model where beneficiaries remaining in traditional  
21 fee-for-service would face a potentially larger premium to  
22 stay. Those are the sort of issues that I often hear in

1 talking to people about this on the Hill. And those are the  
2 sort of issues, I think, that made this such a matter of  
3 controversy during MMA.

4 From my perspective the pure competitive bidding  
5 model has a lot of positive attributes. These issues that  
6 you identify, though, are so important, and the difference  
7 of opinions on them so great, I'm not sure -- it would be  
8 presumptuous to think that an opinion from MedPAC would  
9 materially alter where people come down on that.

10 And so whatever its conceptual merit, I'm not sure  
11 that we could have a big breakthrough there. But even if we  
12 can't do that, my hope is not to avoid the months long  
13 discussion. I think that we can, maybe more quickly, focus  
14 in on some potential improvements in MMA 2006 that would be  
15 in accord with the sort of values that I've outlined.

16 Scott alluded in his presentation, just in  
17 passing, to one variation which would be to say let's have  
18 bidding. Fee-for-service beneficiaries are not expected to  
19 pay more if that's their option. So we have private plans  
20 bidding perhaps below the benchmark.

21 But as opposed to taking 25 percent of the savings  
22 out and putting it in the federal treasury, maybe what we

1 ought to do is take that money and recycle it into  
2 productive investment if it improves the quality of care,  
3 reward excellent performance where it exists, as opposed to  
4 spreading the money indiscriminately across anything that is  
5 called private.

6           That's a relatively modest change in the  
7 framework. It would be in accord with the most basic notion  
8 of neutrality in that the total payments going out would be  
9 benchmarked to 100 percent of fee-for-service. It would  
10 help us get some competitive forces determining in each  
11 market what an efficient level of cost is with an  
12 opportunity for the beneficiaries in the program to benefit  
13 from moving away from a pure administrative price.

14           That's an idea that I'd like to see us talk about  
15 as an incremental change short of engaging in the months  
16 long philosophical discussion.

17           DR. REISCHAUER: I might be looking at this a  
18 little simplistically, but I don't have the problem that  
19 Bill raised. He was saying that here we're looking at  
20 financial neutrality and there are other objectives that  
21 trump, in a sense, financial neutrality in his mind,  
22 quality, efficiency, protecting low income people. I guess

1 I looked at financial neutrality holding everything else  
2 constant.

3 First of all, efficiency should be caught up  
4 really in financial neutrality because if you're more  
5 efficient there is value that is being captured somewhere,  
6 maybe incorrectly, in the system we're having.

7 But I don't see why quality, in a sense, isn't  
8 completely separable from financial neutrality. You're  
9 talking about financial neutrality of situations where you  
10 have the same quality and we want to reward good quality and  
11 penalize bad quality. There are other various other  
12 mechanisms that we try and use to help low income people to  
13 make sure that they can pay the copayments, premiums or  
14 whatever. And maybe they aren't as extensive as they should  
15 be. But we shouldn't try and mesh that in somehow with the  
16 plan kind of system.

17 Jay raised the issue of looking at the chart with  
18 a different label on the X axis, that being time, and  
19 suggesting that there was an investment aspect to this. I  
20 wasn't sure if you were talking about the investment in  
21 creating a different system or you were speaking -- this is  
22 what I thought you were speaking about -- that the longer an

1 individual remains in a managed-care type of structure the  
2 greater the payoff down the line. I believe that to be  
3 true.

4 But if you're tying payments to fee-for-service,  
5 which gets none of that, presumably we're already paying for  
6 it in a sense and paying for it more and more over time.  
7 And alternatively you could change the capitation such that  
8 it was not only risk adjusted but length of time in other  
9 system adjusted, as well, if you really thought this were  
10 great.

11 But I don't see why necessarily, for an entity  
12 like yours, which has sort of a mature profile of  
13 participants, you aren't already capturing that. We're  
14 overpaying people who have been in there a long time, in  
15 some sense, if these benefits are there and underpaying  
16 those who just joined.

17 DR. CROSSON: Thanks, Bob. Just to clarify, I  
18 actually was talk about the former concept, not the latter  
19 concept.

20 DR. REISCHAUER: But the problem --

21 DR. CROSSON: Let me finish. Specifically, the  
22 time for organizations, and I can't speak for all

1 organizations, I have to say that. But specifically the  
2 time for organizations to implement oddly the same kinds of  
3 process we've been talking about in Medicare fee-for-  
4 service, for example effective profiling, pay for  
5 performance, disease management programs, and the utility,  
6 attaining the utility of clinical information technology in  
7 the managed-care environment.

8           Now some organizations use those effectively.  
9 Others are still trying to figure out how to use those.  
10 These are, for the most part, newer techniques than I think  
11 what we saw to some degree in the 1990s. Again, I can't  
12 defend all situations but I'm just saying that there's an  
13 argument to be made here that if we want to get to the right  
14 side of that curve there is a justification for making  
15 investments.

16           To the extent that those need to be made budget  
17 neutral, as we had to do with pay for performance, I can  
18 understand that. But I can also understand advocates who  
19 would say that we need to make an absolute investment in  
20 this, because of the complexity of that, to get to where we  
21 want to be.

22           DR. WOLTER: Glenn, for those of you that have

1 been thinking about this, if our page 20 is a potential  
2 policy direction or some version of it to create more  
3 competition that would have more effective results, what  
4 thoughts have you had about rural areas? Is this intended  
5 to be an urban sort of focused program? Is there a way for  
6 rural areas to be considered in all this? Or is the thought  
7 that more likely under a scenario like page 20, rural areas  
8 would just stay with fee-for-service?

9 DR. MILLER: One thought is by moving off of a  
10 national benchmark and going to a local area benchmark you  
11 have some greater possibility for that happening. But I  
12 also don't want to overstate it.

13 Given the cost function illustration that Scott  
14 has there, there is sort of a systematic problem with rural  
15 areas that you have this fixed cost barrier that you have to  
16 get over before you can get the plan.

17 MR. HACKBARTH: My thought on it is, of course we  
18 want quality of care to improve in rural areas as well as  
19 urban. The tool of competition among private plans,  
20 however, may be less applicable given lower population  
21 levels, pure providers, less opportunity for meaningful  
22 competition. And therefore, we may have to look at other

1 devices to achieve the same results in very different market  
2 circumstances.

3 To pretend that rural markets are like urban  
4 markets, I think is folly. All we do is we throw in more  
5 money until we get private competition. We're going to have  
6 to throw a lot of money into the pot.

7 I think what I just described is one of the  
8 reasons why some people inserted regional PPOs in MMA. I'm  
9 not sure that I agree with all of the elements of the logic,  
10 but the logic was okay, let's not depend on competition  
11 among local private plans. Let's set up a regional PPO and  
12 effectively require participation in broad geographic areas  
13 that also include rural areas. So just throwing money at  
14 private plans and keep upping the amount until we get enough  
15 private plans in is not a very appealing option to me.

16 Now whether I endorse the regional PPO, that's  
17 sort of a separate discussion, but we need to look at  
18 alternative paths as opposed to just increasing payments, is  
19 my take on your question.

20 DR. WOLTER: I certainly wouldn't suggest that we  
21 just throw more money in hopes that lots of plans would come  
22 into Montana and North Dakota.



1           MR. HACKBARTH: I think that that's what we've  
2 been doing.

3           DR. WOLTER: But I do think that some of the  
4 opportunities created that allow benefit structures to be  
5 richer for beneficiaries or allow investment in chronic  
6 disease management or whatever, it would be wise to look at  
7 what ways can we approach that for rural areas, as well.  
8 And there might be different tools.

9           MR. HACKBARTH: I agree with that. What I don't  
10 want is the need to have private plans in rural areas become  
11 a fundamental design constraint on developing a system that  
12 applies to every place else in the country. I think that's  
13 just misplaced emphasis.

14          DR. BERTKO: Scott, could you put up one of your  
15 recommendation slides because I'd like to now talk about  
16 offsetting technical fouls, if I can use one of Bob's  
17 favorite metaphors.

18                 Given that there are two parts here, possibly, to  
19 the payment question, the IME part is one you're suggesting  
20 we make a specific recommendation on. And for another time,  
21 I will again remind the Commission that missing from the  
22 payment mechanism today is, I think, an agreed upon

1 technical flaw which is that anybody in that VA/DOD system  
2 who receives care doesn't have the cost of that care counted  
3 in the way the calculation is done.

4           So if there are 20 of us around the table who are  
5 all Medicare eligible, and 19 of us get paid through the  
6 fee-for-service system and one gets their total care from  
7 say the VA system, the calculation shows 20 people in the  
8 denominator and 19 cost of care in the numerator.

9           From the background reading and from ancient  
10 gossip, the magnitude of those two things appear to be  
11 roughly offsetting technical fouls.

12           The MMA actually, I believe, instructs CMS to put  
13 the money back in and CMS has declined to do it in this year  
14 once again because it is a difficult number to calculate. I  
15 accept that completely. But it's out there and it's missing  
16 and it's a technical flaw that is of the same nature as this  
17 technical flaw.

18           DR. REISCHAUER: But with a very different  
19 geographic distribution.

20           DR. BERTKO: Agreed. It varies by where the  
21 people are but across the country it is, I think, rumored to  
22 be in the same kind of rough size range.

1 DR. HARRISON: CMS has had a lot of trouble  
2 getting the data to do that adjustment. There is a  
3 theoretical difference too, in that VA people who join plans  
4 can still use VA facilities. And so the cost to plans may  
5 also be a lot lower.

6 DR. BERTKO: Yes, and I would suggest that that is  
7 de minimus for most plans today.

8 MR. MULLER: I thought I could get through a year  
9 without an IME discussion.

10 That this was incorporated in the BBA in '97, as  
11 well, and the '99 and 2000 amendments, they averaged the IME  
12 in and they took it back out. I think we should continue  
13 our discussion about how a very complicated system ensues.  
14 I think throwing this IME recommendation here, it's not  
15 quite clear to me why we're putting it up at this time, in  
16 part because we dealt with it once in policy and took it  
17 back out and we now make direct payments to the hospitals  
18 for the IME that's included in the Medicare plans.

19 MR. HACKBARTH: That's not the issue that's raised  
20 by the draft recommendation. What we're getting at in the  
21 draft recommendation is that the separate payments are made  
22 to the teaching hospitals. But then the money is also

1 included in the payments to the private plans.

2 MR. MULLER: I understand that and there are at  
3 least two ways, if not more ways to fix that. One is, and I  
4 heard John speaking about if you take it out of the plan  
5 payments you have to then also take into account these VA  
6 payments that aren't in. So the alternative then is to take  
7 them out of the hospital payments.

8 My point is those IME payments are targeted in  
9 public policy, and we've had this discussion many times, for  
10 very specific purposes. Why we should then leave it to the  
11 plans to distribute them to hospitals when they might feel  
12 this is a make up for VA payments or something else, I'm not  
13 sure it's the right time to take that kind of issue on.

14 I'm a little hesitant to start going down the  
15 course of making this the one recommendation that we focus  
16 on out of this whole fairly contemplated policy area.

17 MR. HACKBARTH: Bill wants to go, but just again  
18 about what's shown up as a draft recommendation versus what  
19 has not. That one was put up as a draft recommendation  
20 because it seemed like it was pretty straightforward based  
21 on previous MedPAC discussion. I would not envision that  
22 that would be the sole recommendation. We're trying to see

1 if there are some additional elements. And when we switch  
2 the presenters here in a minute, you'll see some other draft  
3 recommendations, as well. So it's not going to be  
4 considered in isolation.

5 DR. SCANLON: I would just respond a little bit to  
6 Bob. You started off by saying that things seemed more  
7 simple then. Maybe it was portraying them. But I think as  
8 you went on you kind of introduced some of the complexity in  
9 it.

10 I think that some of our differences in terms of  
11 how complex this is maybe goes to the issue of what are the  
12 assumptions that lead us to be able to evaluate whether  
13 something is neutral. My sense is we need to be explicit  
14 about what those assumptions are and then we need to  
15 determine whether or not they're truly valid.

16 Glenn earlier talked about the issue of risk  
17 adjustment in the past slowing or deterring MedPAC from  
18 thinking that a simple comparison should be made. I again  
19 raise the issue that we don't have the experience with risk  
20 adjustment.

21 You introduced trying to protect low income  
22 individuals. Just on that alone, thinking that we heard

1 that the proposal in the President's budget for Medicaid is  
2 to extend the Q1 program for one year. But it's denominated  
3 in terms of a national poverty level. So we've introduced  
4 geographic variation here. Again, the complexity needs to  
5 be explored. I understand fully what the impact is going to  
6 be.

7 We've also been talking about MA as a single  
8 entity. We should be thinking potentially about the fact  
9 that there are multiple types of plans within MA. Do we  
10 want to encourage them all? Or do we want to encourage some  
11 of them more than others?

12 That's the kind of discussion I think we need to  
13 have as part of this idea of neutrality.

14 DR. MILLER: That's an excellent segue.

15 MR. HACKBARTH: So we're going to switch gears now  
16 and move from the premium setting financial issues to some  
17 other issues, one of which is regional PPOs.

18 DR. MILLER: Sarah, if you can tell them what  
19 handout they'll be working in and all that.

20 MS. THOMAS: You should go to the first half of  
21 your MA package. And then after I go through some of the  
22 perhaps less complicated issues in MA, then Dan is going to

1 talk a little bit about the mandated report payment areas  
2 and some other aspects of risk adjustment other than the  
3 ones he just covered.

4 I'm going to talk about types of plans, quality,  
5 enrollment provisions and benefits.

6 This chart, I will be real quick. It just  
7 summarizes some of the key changes to the program for  
8 private plans. Scott has talked to you in depth about the  
9 last block but I also wanted to mention types of plans,  
10 added regional PPOs and specialized plans. It's shifted  
11 enrollment from a month to month process to an annual one.  
12 And of course, the law added outpatient drug benefits to  
13 Medicare. And some types of plans, but not all, must offer  
14 this coverage to their enrollees. I'm going to hit one  
15 issue here that's listed on this chart under benefits that's  
16 really a carryover from the earlier law.

17 Regional PPOs. Legislators, as we discussed  
18 earlier, hope that requiring plans to serve larger regions  
19 will bring them to more parts of the country. The logic  
20 will be that in order to serve the urban areas of the  
21 regions, that plans will agree to serve rural ones as well.  
22 PPOs are very popular in the non-Medicare populations so the

1 hope is that they will attract Medicare beneficiaries, as  
2 well.

3           Much as it did for the drug plans, CMS defined 26  
4 regions for these regional PPOs following a market analysis.  
5 The drug regions are nested within these 26 regions. The  
6 key factors it looked at, very similar to the drug  
7 situation, were population size, at least 200,000 eligible  
8 beneficiaries but no more than 3 million, sufficient number  
9 of existing competitors, limited variation in payments  
10 within regions, and grouping states where beneficiaries  
11 typically receive care across state borders.

12           PPOs main tool to get enrollees to use their  
13 preferred providers is to offer different cost sharing,  
14 lower cost sharing to use in-network providers and higher  
15 cost sharing when you go out of network. It is the case  
16 that for most Medicare local plans that they much show that  
17 the overall cost sharing for their benefit package is no  
18 more than the fee-for-service program. For regional PPOs  
19 this is only true for in-network services.

20           Regional PPOs must have a combined deductible for  
21 Part A and B services and cap beneficiaries' total out of  
22 pocket liability for these services. The cap may differ for



1 in-network and out-of-network services. Neither the law nor  
2 regulations sets a level for these benefit parameters.

3           Regional PPOs can contract with CMS with less  
4 robust networks of providers than required of local  
5 coordinated care plans. These plans will meet CMS's access  
6 requirements as long as they pay providers with whom they do  
7 not contract at fee-for-service rates and limited enrollee  
8 cost sharing to those that would apply under the in-network  
9 levels. For example, a regional PPO may establish a network  
10 that meets the normal access requirements in 85 percent of  
11 the region. In that area, the PPO could charge higher cost  
12 sharing for beneficiaries who go out of network there. But  
13 in the remaining 15 percent of the region without a network  
14 the plan would not charge higher cost sharing for out-of-  
15 network services.

16           DR. REISCHAUER: Can I just ask you a question?  
17 Are we talking about where the participant lives or where  
18 the provider is?

19           MS. THOMAS: I don't know. Do you know, John?

20           DR. REISCHAUER: Imagine the situation in which  
21 the individual lives in a rural area where there is no  
22 network and chooses to go to an out-of-network doctor in an

1 urban area near.

2 DR. BERTKO: Let me see if I can rephrase and  
3 answer the question. It is really where the provider is  
4 located. So let's suppose there are two kinds of people  
5 here. One person resides in Eureka, California, which is  
6 difficult to contract in. And that person signs up for the  
7 regional PPO because it's offered California-wide. They  
8 then get exactly what Sarah said, in-network benefits. The  
9 facility presumably is paid at fee-for-service and they are  
10 okay.

11 MS. THOMAS: It is.

12 DR. BERTKO: Let's suppose my mother-in-law, who  
13 lives in the Bay area, is up in Eureka on a visit and has  
14 some need for services there. She's staying for a week's  
15 vacation in Fog City. She would then have the same benefit  
16 of being at that provider, in-network services, and she  
17 would have in-network -- the provider would be paid at fee-  
18 for-service.

19 So it's kind of yes to both and it's really  
20 provider dominated, depending on where it is. If again she  
21 is back in the Bay area, though, she can only get in-network  
22 cost sharing by using the facility in Daly City, California.

1 Too complex?

2 DR. REISCHAUER: For the average beneficiary, yes.  
3 For an esteemed member of MedPAC, no.

4 DR. BERTKO: I think actually it's even easier  
5 than that for the beneficiary. They show up in-area, they  
6 find their local facility. And out-of-area they go anywhere  
7 they want.

8 MS. THOMAS: There are three direct financial  
9 incentives to attract regional PPOs. In addition, carriers  
10 cannot offer local PPOs in 2006, the ones that were being  
11 offered before are grandfather in, which also may be another  
12 kind of incentive to offer a regional plan.

13 First of all, risk sharing for regional PPOs is  
14 structured through corridors that compare plan's costs at  
15 the end of the year to their payments. If costs are higher,  
16 CMS will give them additional funds. If costs are lower,  
17 plans must return funds to Medicare.

18 The Regional Stabilization Fund provides \$10  
19 billion as needed to encourage regional PPOs to enter  
20 markets and also encourages them to stay there. The funding  
21 starts in 2007 and ends in 2013 or whenever the funds run  
22 out. The payments are available in three situations.

1 First, a regional plan wants to be the first nationwide plan  
2 and there's no existing regional plan covering the whole  
3 country in 2006. And there's no regional plan serving every  
4 single region. So it wants to be the first national plan  
5 that comes in.

6 Two, a regional PPO wants to be the first to serve  
7 a region and there's no national plan already in place.

8 Three, a regional PPO plan otherwise will depart  
9 from a region, leaving it with fewer than two regional plans  
10 and there's no national plan.

11 If a national plan enters in 2006 and enters  
12 through the period, or if regional plans are in all areas,  
13 then it's unlikely that money will be paid out unless it's  
14 to keep plans in place. No other type of plans have access  
15 to these funds. That is, no local plans have access to  
16 these funds. And you may want to discuss your views of this  
17 policy.

18 Finally, there are essential hospital payments.  
19 Regional PPOs that are having trouble contracting with  
20 hospitals may ask CMS to make additional payments directly  
21 to those hospitals, these are called essential hospitals, to  
22 secure an adequate network. If they meet the test, CMS will

1 pay these hospitals, which are not otherwise critical excess  
2 hospitals, as if they were critical access hospitals.  
3 They'll pay the difference between the PPS amount and the  
4 critical access amount directly to the hospitals. The money  
5 for this provision is limited to \$25 million a year and it's  
6 paid out on a first come, first served basis.

7           You may also want to discuss your views of this  
8 policy. It's inconsistent with the level playing field  
9 argument on a couple of counts. Medicare does pay teaching  
10 hospitals directly for the IME payments of beneficiaries in  
11 private plans but only what it otherwise would pay them  
12 under fee-for-service. This is the only instance where  
13 Medicare pays providers contracting with plans more than it  
14 ordinarily would. And second, again, these funds are not  
15 available to local plans.

16           Another potential issue that we've come up with  
17 relatively recently is the way that regional PPOs bid and  
18 how this bid is adjusted to reflect county payment rates.  
19 We're still working through this and I think we may bring it  
20 to you in April, depending on what we learn and how clearly  
21 we understand it at that point, how it will play out.

22           I'm going to switch gears a little bit now and

1 talk about quality. We looked at quality in two ways, first  
2 how it's changed over time for MA plans. And second, how it  
3 compares between private plans and the fee-for-service  
4 program.

5 HEDIS measures generally show stabilization or  
6 improvement. Patient experience measures collected through  
7 CAHPS show mixed performance over time. However, the  
8 performance, when you compare between Medicare Advantage and  
9 fee-for-service, is fairly similar.

10 Other the patient experience measures, I wasn't  
11 able to find measures of clinical quality to compare plans  
12 to the fee-for-service program. This is notable as you  
13 think about plans competing on two dimensions with the fee-  
14 for-service program, both cost and quality.

15 CMS could calculate the HEDIS measures that can be  
16 derived from administrative data and create composite  
17 measures in the fee-for-service program and then allow a  
18 better comparison of understanding what the different  
19 quality is between the two programs. You may want to  
20 recommend that the Secretary do this to help beneficiaries  
21 evaluate their choices.

22 As with the earlier program, the quality

1 requirements vary by type of plans with regional PPOs  
2 treated like local PPOs. That is those local PPOs that are  
3 not sponsored by HMOs. Most types of plans must have  
4 quality programs of some sort, although the requirements  
5 vary by type of plans and the sets of measures also will  
6 vary.

7           For example, MSA and private fee-for-service plans  
8 do not have to have a quality improvement program. But all  
9 plans, including these, must maintain a health information  
10 system that has to meet certain requirements.

11           CMS will allow some variation in measure reporting  
12 for HMOs and PPOs, at least in the early stages of the MA  
13 program. CMS expects to collect measures from HEDIS, CAHPS,  
14 and the Health Outcomes Survey for both HMOs and PPOs, but  
15 the HEDIS measures will vary. PPOs will not have to submit  
16 HEDIS measures that rely on medical record review.

17           CMS indicates in the preamble to the regulation  
18 that it expects to move to the same measures over time as  
19 PPOs build the capacity to report measures derived from  
20 medical records. Specialized plans may use measures derived  
21 from the MDS, the Minimum Data Set that is applied in  
22 nursing homes, instead if they do target the nursing home

1 populations.

2           There has been some debate lately about whether  
3 plans should have these differing program requirements or  
4 whether these should vary by type of plan. One view is that  
5 plans like PPOs do not set out to manage care or to be  
6 accountable entities. Thus requiring them to report on  
7 quality measures may be inconsistent with their mission and  
8 what they're really setting out to do.

9           Another view is that all plans, regardless of  
10 their structure, and it often is difficult to distinguish  
11 among plans on this level, should have to report on robust  
12 measures of quality. That is those that are derived from  
13 medical records.

14           It can be more expensive for plans to collect  
15 these measures and so there are competitive issues  
16 associated with having different requirements. Also PPOs,  
17 for example, do not provide as high quality as more  
18 organized systems of care. Beneficiaries arguably should be  
19 able to see that in the quality measures, not the lack of  
20 measures. That would be the other side of the argument.  
21 You may want to discuss this issue.

22           You also remember that you recommended pay for



1 performance for Medicare Advantage and we discussed that a  
2 little bit in the last session. CMS has recently stated  
3 that unlike some of the other demonstrations it's pursuing  
4 on the fee-for-service side, it does not plan to test this  
5 concept to Medicare Advantage. It argues the competitive  
6 nature of the program makes this unnecessary.

7 I'm going to shift and quickly talk about  
8 enrollment provisions. MMA implements an annual open  
9 enrollment period. In 2006, the beginning of year,  
10 beneficiaries will choose plans. And then they can switch  
11 again within the first six months but only to a similar type  
12 of plan.

13 Remember now beneficiaries can enroll and  
14 disenroll on a month-to-month basis. And starting in 2007  
15 the six-month window will shrink to a three-month window  
16 for additional switches, and then that will persist on into  
17 the future.

18 I also wanted to point out the law did not allow  
19 all beneficiaries who developed end-stage renal disease  
20 while in fee-for-service Medicare to enroll in Medicare  
21 Advantage plans, which is something that you have  
22 recommended in the past. CMS did decide to allow these

1 beneficiaries to join specialized plans if these plans  
2 decide to enroll them. It's their option.

3           Finally, I want to talk about one benefit issue.  
4 Under the MA program, private plans do not cover hospice  
5 care. This policy works against the goal of fully  
6 integrated health care delivery through private plans. For  
7 all other Medicare covered services under Parts A and B,  
8 Medicare pays a single amount to care for the full array of  
9 Medicare services. This gives plans the incentive to  
10 coordinate all care and choose the most effective setting to  
11 improve quality and lower costs. By contrast, beneficiaries  
12 who elect hospice essentially are moved out of their plan's  
13 care system, which has the effect of discouraging plans from  
14 developing integrated approaches to end of life care.

15           The rationale for this provision goes way back to  
16 1983 when both the Medicare risk contracting program and  
17 hospice benefit were started. At that time the actuaries  
18 didn't know the cost of hospice so left it out. But  
19 hospices also have argued that they have a different care  
20 system and it would be inconsistent with the managed care  
21 companies perspective.

22           On the other hand, if Medicare Advantage were

1 liable for hospice beneficiaries' full spectrum of care,  
2 they'd be more likely to coordinate care across settings,  
3 experiment with innovative end of life care programs. And  
4 indeed, there are some innovative end of life care programs  
5 being sponsored by plans for their broader populations.

6           It's also the current policy of treating hospice  
7 separate from all the other A and B services ends up with  
8 some administrative complexities. And now with Part D  
9 benefits available through plans, it becomes even more  
10 complicated. Plans that offer Part D must continue to do so  
11 for people who are in hospice, even though they don't  
12 typically have to provide all the other A and B services  
13 that they might use.

14           But the hospices are responsible for paying for  
15 drugs for palliation and that's paid through Medicare fee-  
16 for-service. It's very complicated and lots of accounting  
17 has to take place to track this benefit.

18           So integrating the benefit would be more  
19 straightforward and this is the final issue you may want to  
20 discuss.

21           Do you want to talk ahead and talk with Dan or do  
22 you want to stop at this point?

1                   MR. HACKBARTH: We ought to and then we'll have  
2 the discussion.

3                   DR. ZABINSKI: Throughout today we've discussed  
4 substantial changes to the Medicare Advantage program. And  
5 in regard to those changes, the MMA directs MedPAC to  
6 analyze issues related to the payment system in the Medicare  
7 Advantage program. This mandated study has several parts  
8 but today I will focus on two key issues.

9                   One of these issues is that the MMA directs us to  
10 identify appropriate payment areas for Medicare Advantage  
11 plans. I'm sure you know that the county currently serves  
12 as the payment area for MA plans, but we have found that  
13 using counties as a payment area does create some problems.

14                   First, many counties have large annual changes in  
15 their per capita fee-for-service spending. This is  
16 important because the Commission has recommended, as we have  
17 discussed already, paying equally between the fee-for-  
18 service and Medicare Advantage sectors. But if you can't  
19 get accurate estimates of local fee-for-service spending,  
20 there is some uncertainty as to whether you can be confident  
21 of paying equally in the two sectors.

22

1           Also, adjacent counties often have very different  
2 levels of fee-for-service spending, which is important  
3 because payment rates often depend on fee-for-service  
4 spending. If adjacent counties have very different payment  
5 rates, plans may offer less generous in the county with the  
6 lower rate or may avoid it altogether, create appearances of  
7 inequity.

8           The second issue the MMA directs us to address is  
9 risk adjustment for Medicare Advantage payments. Earlier I  
10 presented results from a mandated analysis that assesses the  
11 predictive accuracy of the CMS-HCC, which is currently used  
12 to risk adjust MA payments. In addition, I'll also discuss  
13 a policy where CMS is increasing payments adjusted by the  
14 CMS-HCC to offset a reduction in aggregate payments that are  
15 caused by the CMS-HCC.

16           First, let's discuss our analysis of the payment  
17 areas of Medicare Advantage plans. We considered three  
18 alternative payment area definitions that are larger than  
19 the current definition, the county. In one alternative we  
20 collected urban counties into metropolitan statistical  
21 areas, or MSAs, and then we collected the remaining non-  
22 urban counties in statewide non-MSA areas for each state.

1           In a second alternative, we collected all  
2 counties, both urban and rural, into health service areas,  
3 or HSAs, as defined by Diane Makuc and colleagues at the  
4 National Center for Health Statistics. These HSAs are  
5 collections of counties that are relatively self-contained  
6 with respect to short-term hospital stays among Medicare  
7 beneficiaries.

8           In the final alternative, we created a hybrid of  
9 the first two definitions, collecting urban counties into  
10 MSAs and non-urban counties into HSAs.

11           I apologize to Glenn, I have not updated my  
12 technology on this, but to give you a better sense of how  
13 these three payment area definitions relate to one another,  
14 the next three slides hone in on the panhandle area around  
15 the city of Amarillo, Texas.

16           First, let's consider the MSA/state non-MSA  
17 definition of payment areas. On this slide we show how MSAs  
18 look around Amarillo. The striped areas that are of the  
19 same color are counties that make up an MSA and act as  
20 distinct separate payment areas. The white area is counties  
21 that are not in MSAs and are part of the state non-MSA area  
22 for Texas.

1           I'd like you to pay particular attention to the  
2 orange striped counties in the center of the picture that  
3 make up the Amarillo MSA, because when we turn to the HSA  
4 definition of payment areas those two counties become part  
5 of this larger red area, which is the HSA for Amarillo and  
6 acts as a separate payment area under the HSA definition.

7           And finally, when we consider the MSA/HSA  
8 definition, the two counties making up the Amarillo MSA  
9 again become orange stripes and become a single payment area  
10 on their own. The remaining counties from the Amarillo MSA  
11 remain red and act as a distinct payment area on their own.

12           We used three tools to assess the desirability of  
13 these three alternatives. In one tool we asked would the  
14 payment areas have enough Medicare beneficiaries to obtain  
15 reliable estimates of per capita fee-for-service spending?

16           In the second tool, we asked how well do the  
17 payment areas match the market areas of Medicare Advantage  
18 plans and private sector HMOs? If payment areas do not  
19 accurately match plan market areas, plans may be in  
20 situations where payments are well above costs in some parts  
21 of a payment area and well below cost in other parts.

22           We actually used two measures to analyze how well

1 a payment area matches plan market areas. First, among  
2 payment areas where at least one county is served by one or  
3 more plans, we determine the percentage that have the entire  
4 payment area served by plans. Second, among plans that  
5 serve at least one county of a payment area, we determined  
6 the percentage that serve the entire payment area.

7           Then in the third tool, we asked the question are  
8 the payment areas too large? In large payment areas, the  
9 costs of serving beneficiaries can vary widely by geography  
10 and extremely large payment areas can present a problem for  
11 MA plans because the plans are required to serve the entire  
12 area. The plans may find they are profitable in some parts  
13 of a payment area and unprofitable in others, which may  
14 cause them to avoid the payment area together.

15           We measured the variation in costs within a  
16 payment area as the difference between the per capita  
17 spending in the highest cost county and the per capita  
18 spending in the lowest cost county.

19           Then, when we analyzed how well the three  
20 alternatives measure up to the three analytic tools, we  
21 found the following. First, that the MSA/state non-MSA  
22 definition provides by far the largest beneficiary



1 populations and the most stable estimates of local fee-for-  
2 service spending. The reason this definition performs  
3 better than the others on this measure is the large  
4 state/non-MSA areas that exist in many states such as Texas.

5 But we also found that the MSA/HSA definition is  
6 the best match for plan market areas for both Medicare  
7 Advantage plans and private sector HMOs. We also found that  
8 the MSA/HSA definition has the smallest variation in terms  
9 of the costs of serving beneficiaries.

10 So in response to those findings, we have  
11 developed this draft recommendation. Payment areas for  
12 Medicare Advantage local plans should have the following  
13 characteristics. First, among counties in metropolitan  
14 statistical areas, or MSAs, payment area should be  
15 collections of counties that are in the same state and the  
16 same MSA.

17 Second, among counties outside of MSAs, payment  
18 areas should be collections of counties in the same state  
19 that are accurate reflections of health care market areas  
20 such as health service areas.

21 An issue related to this recommendation is that  
22 plans can currently obtain waivers that allow them to serve

1 only specific portions of a payment area if they can show it  
2 is difficult to form provider networks throughout a payment  
3 area. And we believe plans should have this opportunity to  
4 obtain waivers irrespective of the payment area definition.

5           The spending implication of this recommendation  
6 would be that it should have no direct effect on program  
7 spending.

8           However, the effect on plan participation of the  
9 recommendation isn't unclear. On the one hand, plans may  
10 withdraw from the Medicare Advantage program if the larger  
11 payment areas sufficiently reduce opportunities for  
12 isolating payment areas where payments are favorable  
13 relative to costs. On the other hand, plans may extend  
14 their participation to counties they currently do not serve  
15 if the larger payment areas sufficiently increase payments  
16 in those currently unfavorable counties.

17           Now let's turn to risk adjustment of Medicare  
18 Advantage payments. The current status of risk adjustment  
19 is that, first of all, CMS began using a new system of risk  
20 adjustment in 2004, the CMS-HCC. This model uses  
21 administrative data as well as beneficiaries' conditions  
22 diagnosed in the previous year to predict beneficiaries'

1 costs in the current year.

2 In 2005, 50 percent of payments are risk adjusted  
3 with the CMS-HCC. The remaining 50 percent is adjusted with  
4 a demographic system that uses only administrative data to  
5 predict beneficiaries' costs and has been found to perform  
6 much worse than the CMS-HCC in terms of accounting for  
7 difference in beneficiaries' costs.

8 The CMS-HCC is being phased in with a larger share  
9 of payments being risk adjusted each year with ultimately in  
10 2007 100 percent of payments being risk adjusted. Then, in  
11 2006, CMS intends to adjust the CMS-HCC to include more  
12 conditions than the current model has.

13 Initially, our plan at this point was to discuss  
14 our analysis of how well the CMS-HCC predicts beneficiaries'  
15 costliness, but we had a change in plans and I discussed  
16 that earlier, so we can skip this slide.

17 Now let's turn to this policy where CMS is  
18 currently increasing risk adjusted payments to offset the  
19 effects that risk adjustment has on payments to Medicare  
20 Advantage plans. We know that CMS has estimated that in  
21 2004 and 2005 risk adjusted payments are lower than payments  
22 adjusted by the democratic system in the aggregate. This

1 indicates a more precise measurement by the CMS-HCC of the  
2 favorable selections going to plans.

3           In response to the effect that risk adjustment has  
4 on aggregate payments, CMS is making proportional increases  
5 to all risk adjusted payments so that aggregate payments are  
6 equal to what they would be if 100 percent of payments were  
7 adjusted with the demographic system. The end effect is  
8 that plans are being held harmless from the impacts of the  
9 CMS-HCC in the aggregate but it's true that payments at the  
10 individual plan level can be affected by the risk  
11 adjustment.

12           A new wrinkle in this issue is that the most  
13 recent budget submitted by the President includes a phase  
14 out of this policy so that the risk adjusted payments will  
15 still be increased but by a smaller amount than if this  
16 policy continues in its full force. The President's budget  
17 estimates that under the phase out aggregate payments would  
18 be \$8.3 billion higher from 2006 through 2010 than they  
19 would be with no increase to risk adjusted payments.

20           The motivation for this policy is to promote  
21 stability in the Medicare Advantage program. But even if  
22 this policy is phased out, I want to emphasize that any

1 policy that increases risk adjusted payments is inconsistent  
2 with MedPAC recommendations. In particular, the Commission  
3 has recommended risk adjusting payments with a comprehensive  
4 system such as the CMS-HCC.

5 In addition, we have recommended that payments  
6 should be neutral between the Medicare Advantage and fee-  
7 for-service sectors. That means that, on average, payments  
8 should be equal in Medicare Advantage and traditional  
9 Medicare after accounting for differences in risk. It's the  
10 job of risk adjustment to account for those differences in  
11 risk and put the MA and fee-for-service sectors on a level  
12 playing field. But this policy that holds plans harmless  
13 from the impacts of risk adjustment has the effect of moving  
14 us away from the concept of a level playing field and  
15 payment neutrality.

16 In response, we have developed this draft  
17 restatement of a recommendation that we made in the March  
18 2004 report. CMS should continue to risk adjust payments  
19 with the CMS-HCC system but should not continue to offset  
20 the impact of risk adjustment on overall payments in 2006  
21 and subsequent years.

22 The spending implications of this recommendation

1 is that it would not increase Medicare spending relative to  
2 current law. However, the President's budget, as I  
3 mentioned earlier, projects additional spending of \$8.3  
4 billion above the risk adjusted level as the policy is  
5 phased out. Consequently, this recommendation may affect  
6 plans because they may develop strategies assuming risk  
7 adjustment payments will be increased according to the  
8 proposed phase out.

9           Therefore, this recommendation may cause plans to  
10 reduce the generosity of their benefits and reduce the  
11 extent of their participation in the Medicare program.

12           That concludes my presentation and I'll turn it  
13 over for discussion.

14           MR. HACKBARTH: Sarah, would you put up -- it's  
15 page 10 in our packet, on the Medicare Advantage policy  
16 issues. Summarizes possible recommendations.

17           We've got roughly a half-hour between now and our  
18 scheduled public comment period; is that right? So on the  
19 table for discussion are these issues.

20           In addition to these, the IME issue that we  
21 alluded to earlier, the proper geographic unit that Dan's  
22 been talking about, the hold harmless budget neutrality of

1 the risk adjustment phase-in, and then any of the neutrality  
2 issues in payment that we were discussing earlier.

3 Let me see a show of hands of who wants to -- why  
4 don't we start with Sheila and we'll just move down this  
5 way.

6 MS. BURKE: Glenn, if I can, I'd like to step away  
7 from the list of recommendations for a moment, although I  
8 want to come back to it and talk about hospice. Can we go  
9 back to the chart that showed Amarillo for just a moment? I  
10 want to be sure that I understand what ultimately you were  
11 proposing, which of the scenarios in terms of the  
12 combination of payments.

13 DR. ZABINSKI: The recommendation most closely  
14 reflects the third one.

15 MS. BURKE: That's what I want to understand.  
16 Would you go back to that for me for just a second?

17 DR. ZABINSKI: The idea is that the solid colored  
18 counties, those blocks are all counties. The solid colored  
19 counties all represent counties that make up a HSA but are  
20 outside of MSAs. And then the striped counties make up  
21 MSAs. Like in the lower right corner, I don't know what  
22 city that is but that's another MSA.

1 MS. BURKE: And so let me understand what you were  
2 proposing. The payment essentially would have two portions.  
3 One would be specific to Amarillo, to the stripes.

4 DR. ZABINSKI: Right.

5 MS. BURKE: Which would take into consideration  
6 the costs in that area.

7 DR. ZABINSKI: Exactly.

8 MS. BURKE: Separate from that would be all the  
9 red areas, the presumption being that is a market.

10 DR. ZABINSKI: Right.

11 MS. BURKE: And so those costs would be calculated  
12 on the basis of that market.

13 DR. ZABINSKI: That's right.

14 MS. BURKE: That's what I thought. I just want to  
15 be sure that I understood that and I visualized it  
16 correctly.

17 Tell me, having done this analysis nationwide, how  
18 clean is that analysis?

19 DR. ZABINSKI: In what sense?

20 MS. BURKE: I'm less worried about the MSA than I  
21 am about anticipating or understanding what the market is  
22 outside of the MSA.



1 DR. ZABINSKI: Okay.

2 DR. REISCHAUER: It's not a market, it's a payment  
3 area. The market is the HSA. We're cutting out the core of  
4 the HSA because service utilization in the balance of the  
5 HSA ex-Amarillo is significantly lower; right?

6 DR. ZABINSKI: That's generally the theory, yes.  
7 The idea was to establish something larger -- the starting  
8 point was established payment areas that are larger than the  
9 counties because the counties present some problems. Then  
10 we took the step forward and said okay, what are our  
11 alternatives? In one, we said okay, MSAs and then the rest  
12 of a state is just non-MSA. A second one we said okay,  
13 let's combine all counties, whether they're urban or rural,  
14 into these HSAs. And then this one here is a third one.

15 The first alternative, the MSA/state non-MSA area,  
16 we just felt that the state non-MSA areas are just too big.  
17 There's too much variation.

18 MS. BURKE: Help me understand. I conceptually  
19 see where you're going and don't disagree. But I want to  
20 understand. for example, the turquoise and whatever that  
21 pink.

22 DR. ZABINSKI: Those are other HSAs.

1 MS. BURKE: Those are other HSAs but they are  
2 distinct enough. The way this particular area is  
3 configured, I'm trying to understand what our presumptions  
4 are. You've got two reds and a purple down below Amarillo,  
5 a purple and then two purples below it. And I'm trying to  
6 understand what our presumptions are about how unique these  
7 areas are and how reflective they are on consistency in  
8 terms of utilization, and therefore pricing.

9 DR. ZABINSKI: That's the whole idea of them. All  
10 of the red ones have -- they're self-contained in terms of  
11 short-term hospital stays among Medicare beneficiaries. And  
12 all of the purple ones are, as well. Basically, the idea is  
13 that the beneficiaries in that area get their care within an  
14 area and not many beneficiaries are coming from outside to  
15 get care in that area.

16 MS. BURKE: Presumably, that is unique because of  
17 the location of tertiary facilities and because of delivery  
18 systems. And we are capable, through the current data we  
19 have, to know how unique -- I mean, the fact that you've got  
20 a bunch of mustards surrounding the purples that are  
21 seemingly quite distinct in distance, one would wonder  
22 conceptually, as you look at that, what is so odd about the

1 distribution system that would have the purples interfere in  
2 the mustards?

3 MR. HACKBARTH: I don't know anything about this  
4 part of Texas.

5 MS. BURKE: I don't know anything about Texas.

6 MR. HACKBARTH: It could be roads, major roads,  
7 geographic features that influence where people tend to go  
8 for their health care services.

9 MS. BURKE: And so we are convinced that we, in  
10 fact, can be accurate enough because of the data that tell  
11 us the billing patterns that these unique --

12 DR. ZABINSKI: These colored areas were developed  
13 by NCHS researchers.

14 MS. BURKE: The Medicare data is adequate that we  
15 feel comfortable with this?

16 DR. ZABINSKI: Yes.

17 DR. REISCHAUER: The reference you gave was a 1991  
18 reference. I assume they've been updated since then.

19 DR. ZABINSKI: Actually, no, they have not.

20 MS. BURKE: Well then, that presents its own set  
21 of issues.

22 DR. REISCHAUER: That presents its own. And the

1 thing to note about the mustards is what they really are is  
2 the non-white and yellow striped part of the HSA that was  
3 associated with the whatever that metropolitan area is. So  
4 it's not really so --

5 DR. ZABINSKI: I believe that is Lubbock. I know  
6 Texas.

7 DR. SCANLON: Just as a clarification, could I ask  
8 -- didn't you, even though these are 1991 areas, use current  
9 data to assess them?

10 DR. ZABINSKI: Yes, right.

11 DR. SCANLON: The counties are historical, too,  
12 and the comparison was of current data by county, current  
13 data by these areas, current data by MSAs.

14 DR. REISCHAUER: But conceivably, if somebody  
15 plunked down a wonderful hospital somewhere else, we would  
16 recharge them.

17 MS. BURKE: But how quickly would we pick that up?  
18 Bill, to your point --

19 DR. REISCHAUER: It's probably been 15 years since  
20 this data or longer, since this data -- I mean, the thing  
21 was published in '91.

22 DR. SCANLON: Not the data used to evaluate them.

1 The data we used to evaluate them are current data; right?

2 DR. ZABINSKI: Right, in terms of how well they  
3 match current service areas from plans, that's current.

4 DR. REISCHAUER: Service area, yes. But a lot of  
5 these areas, there is no plan in them.

6 DR. ZABINSKI: True.

7 MS. BURKE: But so I understand, the data that we  
8 are using is current enough to know whether three hospitals  
9 in the purples have shut down.

10 DR. REISCHAUER: The data we're using is  
11 utilization; right? It has nothing to do with service  
12 patterns. It's aggregate service use.

13 DR. ZABINSKI: In developing these things, yes,  
14 service use was what was used to develop them.

15 DR. REISCHAUER: But not location.

16 MS. BURKE: The service use should track that  
17 pattern.

18 MR. HACKBARTH: They reflect where they go for the  
19 service.

20 DR. ZABINSKI: Exactly. It's patterns of use.  
21 The idea is to get very self-contained areas so we don't  
22 have people going in or out. Most of the care, the people

1 live there and they get their care within that area. And  
2 there's not many people from areas outside of there coming  
3 in to get care there.

4 DR. REISCHAUER: That analysis was done before  
5 1991.

6 DR. ZABINSKI: Right.

7 DR. REISCHAUER: It's not the stuff, the  
8 calculations you did with more recent as what I'm saying.

9 DR. ZABINSKI: Right.

10 MS. BURKE: Let me try and understand this. Do we  
11 know today that the purples are being serviced by existing  
12 capacity in the purple area? Or does this reflect usage  
13 from 1991 when the service capacity might have been  
14 different?

15 DR. ZABINSKI: The latter.

16 MS. BURKE: That's not what you said before. So  
17 now I really am trying to understand how current this is.

18 MR. MULLER: It's '91 cohorts of service, which is  
19 the way he responded, with current utilization.

20 MR. HACKBARTH: What I would hope we would do,  
21 patterns of care change. Populations change, new  
22 institutions are built. So I would hope we would never

1 endorse a particular definition of what the markets are in  
2 North Texas and say this ought to be used in perpetuity for  
3 Medicare.

4 MS. BURKE: No, my concern is that we're not  
5 endorsing a model built on data that is, to start with, 20  
6 years or 10 years or whatever it is old.

7 MR. HACKBARTH: So what I'm thinking, I think is  
8 consistent with that, Sheila, is what we would endorse is  
9 the analytic method of building HSAs using appropriately  
10 recent data regularly updated so that it reflects how  
11 markets have changed and patterns of travel have changed  
12 over time, as opposed to endorsing using 1991 defined --

13 DR. ZABINSKI: And if you read the draft  
14 recommendation, that's why I worded it the way I did, is it  
15 says some system where you have relatively self-contained  
16 health care systems such as health service areas.

17 MR. HACKBARTH: So this is an example of what it  
18 looked like using 1991 data as opposed to necessarily the  
19 map that would be used for Texas in 2008.

20 MS. BURKE: But let's take your question to the  
21 next point, which is is that data available?

22 DR. ZABINSKI: I suppose it is, yes.

1 MS. BURKE: Let me make sure I understand. We  
2 suppose that the data is currently available that is current  
3 that can tell us this. That is, if you live in Merced,  
4 California, whether you get serviced out of Modesto or  
5 Fresno? We know that? That data it is currently available,  
6 so that we can build a payment system based on current data  
7 because it is current and it is updated routinely.

8 DR. ZABINSKI: The people at NCHS said they would  
9 redo these things for us, if requested.

10 DR. REISCHAUER: You should request it. But just  
11 in addition, if you could press a button and say should we  
12 stick with the county system or with this out of date  
13 mechanism, I'd press the button and go for the out of date  
14 system over what we have now. I mean, metropolitan areas  
15 plus HSAs as defined in 1991. I don't think it's too hard  
16 to update the HSA thing. There's also the Wennberg stuff  
17 with the hospital referral district. And I think that  
18 really is more modern.

19 DR. ZABINSKI: But not much.

20 DR. REISCHAUER: Really?

21 DR. ZABINSKI: My understanding is they haven't  
22 updated those in awhile.



1 MS. BURKE: My only concern is, I'm like Bob, push  
2 the button. But what I don't want us to do is to go down a  
3 track that repeats some of the promise we face today which  
4 is data that is so old that we are building a system based  
5 on data that will never be relevant and that patterns and  
6 prices are going to be outdated before we do it.

7 MR. HACKBARTH: I agree with that. And then  
8 again, my assumption was that we were endorsing not a  
9 particular map but a method and approach to defining areas  
10 that I don't think we need to specify what the appropriate  
11 intervals are for updating, but necessarily it is something  
12 that requires regular updating using more recent data so  
13 that we're connected to reality. We would reflect that in  
14 the text.

15 MS. BURKE: Great.

16 Now can I just go back to your earlier list, to  
17 the list of areas of recommendations. And only to suggest  
18 the following. This is a topic that I would hope we would  
19 come back to and discuss in greater detail to fully  
20 understand the impact. And that is the issue of hospice  
21 care.

22 You are right, Sarah, there were a variety of

1 reasons we did what we did in 1983. There were questions  
2 about what we truly understood at the time and didn't  
3 understand about hospice care and about its costs. There  
4 were great fears about whether we could protect time, the  
5 requirements about people choosing between traditional care  
6 and palliative care were our own lack of understanding about  
7 how people made those decisions and the likelihood where  
8 people would bounce back where and the ultimate cost would  
9 exceed our prior costs.

10           Having said that, we have come a long way. And I  
11 am, in fact, very concerned that hospice remains  
12 underutilized because of the failure of the system to fully  
13 appreciate and integrate it into people's expectations. And  
14 that there is this sort of division where people have to  
15 make these decisions in a way that doesn't fully appreciate  
16 the sort of intricacy of that relationship.

17           So I can conceptually think very much we ought to  
18 integrate it more into the traditional view of what a range  
19 of services ought to be. But I want to be certain before we  
20 make the statement that we understand the risks of doing  
21 that, we understand what the relationships are today.

22           So in the course, over the next month or so, as we

1 look at these in more detail, a lot of the work that you  
2 guys have done in the past recently about hospice, I'd like  
3 to come back to fully understand what the relationships are  
4 and what risks there might be in putting it into a benefit  
5 package.

6           Because in no way do I want to, in any way,  
7 disadvantage hospice or put it at any risk. But it is not  
8 what it ought to be today because of people's failure to  
9 understand it as part of a basic benefit people ought to  
10 have.

11           DR. STOWERS: I agree with pushing the trigger to  
12 go on. I'm just wondering with the HSA thing being as old  
13 as it is and Medicare having really switched, also at the  
14 risk of shutting down any discussion over the definition of  
15 rural, but really where Medicare has gone now or CMS is to a  
16 metropolitan service area, micropolitan service area and  
17 then rural. That's gone through extensive research. All  
18 the definitions of rural hospitals, where all the grant  
19 programs go, are all over these new service areas which tend  
20 to break states down into three categories as opposed to the  
21 panhandle of Texas -- I won't make you go back to it, where  
22 you have eight colors, it actually breaks the panhandle of

1 Texas into three colors. It's supposed to be based on  
2 service areas just introduced this last year, I think. This  
3 less than 18 months old in data.

4 I'm just wondering why we didn't go that direction  
5 and went back to the old HSA thing?

6 DR. MILLER: Can I ask something here? I thought  
7 that CMS chose not to pick up the micropolitan areas in its  
8 payments. At least so far.

9 DR. STOWERS: Location of critical access  
10 hospitals and all of that, it's still in effect. Maybe I'm  
11 wrong.

12 MS. THOMAS: Not for the hospital wage index, is  
13 what I think.

14 DR. STOWERS: I'm just saying this is more current  
15 data on where service areas are and so forth. I was just  
16 curious why -- or was that looked at as a possibility of not  
17 having seven or eight different regions in the panhandle of  
18 Texas, which to be very honest, having been out there a lot,  
19 is very uniform in services once you get out of Amarillo.

20 MR. HACKBARTH: You've got a huge advantage, in  
21 terms of knowledge of Texas. My understanding of the  
22 micropolitan areas, that's sort of a byproduct of the MSA

1 process. The Commerce Department says there's another type  
2 of aggregation but it's not health specific. So this has to  
3 do with broader commercial patterns and commuting patterns  
4 and the like.

5 This on the other hand, if it's using  
6 appropriately updated data and the like, is actually  
7 specific to health care use patterns and where people go for  
8 their health care.

9 Conceptually, that might be an advantage that  
10 would make it more likely to track with plan market areas in  
11 some of the tests that we're applying. Let me put a  
12 question mark at the end of that. That seems logical to me.

13 DR. ZABINSKI: I agree with that, yes.

14 MS. RAPHAEL: I was just wondering if we could  
15 organize this in a way that would make it easier to deal  
16 with, because right now I'm having a hard time trying to put  
17 it all together. And also I'm not entirely clear what's a  
18 mandated study and what we're doing apart from the mandated  
19 study.

20 I see this as one part of this is trying to get  
21 payments to be more accurate and closer to costs, something  
22 that you raised earlier, Glenn. And I have a question about

1 what we know now about the accuracy of payments to costs  
2 because I don't have a good sense of that overall.

3 And under that, I put the bonus payments and the  
4 essential hospital provision and the IME. I don't know  
5 whether or not I put the issue of neutrality under that.  
6 And I'd like to better understand whether it fits under that  
7 umbrella.

8 Then I think under quality, part of that for me is  
9 better targeting payments. And that kind of harks back to  
10 something we had recommended, I believe last year, which was  
11 tying payments to Medicare Advantage to quality results.  
12 And I'm not entirely sure whether what we're doing on  
13 quality is tied to how I think about targeting.

14 And then we have another area of benefits, which I  
15 think only involves hospice but I'm not sure. So I just  
16 think I'd like to see some different organization of all  
17 these threads.

18 DR. MILLER: We can decidedly do that. Maybe what  
19 we do in this conversation is talk about some of your  
20 interest on the specific issues, and when we come back  
21 distinguish between what's in the mandated study, which is  
22 predominantly the geographic area, and the risk adjustment,

1 those two pieces.

2 Not just to complicate your typology, if you woke  
3 me up in the middle of the night I would think that risk  
4 adjustment is also a payment issue. And I think your list  
5 was about right, that the bonus payments, the essential  
6 hospital, the IME, the budget neutrality, and the broader  
7 neutrality discussion without implicating anybody's  
8 position, that all feels like payment issues to me.

9 To respond to your quality point, these are, in a  
10 sense, not changing anything that we're saying about pay for  
11 performance. It's more about what measure sets and how  
12 comparable they are across the different types of plans, I  
13 think is really the issue that we're focusing in on the  
14 quality. And then you're correct, the benefit piece on  
15 hospice is kind of a benefit piece that stands on its own.

16 But we can come back with a much clearer typology.  
17 We switched some order here this morning, which is some of  
18 the reason that we've been moving across. And I apologize  
19 for that. But in the end, we thought that there was a  
20 certain logic to housing things together. Perhaps it didn't  
21 work, but that was the idea.

22 DR. CROSSON: Thanks. I have two things. I have

1 a question on the geographic payment area and then a comment  
2 on the risk adjustment budget neutrality issue.

3 The payment on the geographic area is just to  
4 understand why we end up splitting dual state metropolitan  
5 statistical areas. I want to understand that.

6 With respect to the risk adjustment issue, again  
7 not to necessarily speak to the decision that was made by  
8 the CMS Administrator to create this policy. I know there's  
9 a good deal of difference of opinion about that. But I  
10 would like to point out one issue that, at least in our own  
11 organization and I believe in others, influences the timing  
12 of the phase out, because I think that's the new question  
13 here.

14 That has to do with the reality, I believe, that  
15 earlier risk assessment data appears to understate  
16 beneficiary risk where providers are not used to and don't  
17 understand the process of coding, particularly as it relates  
18 to secondary diagnoses. That certainly has been our  
19 experience.

20 Secondly, it has turned out to be much more  
21 difficult than you might intuit to get that to change. When  
22 you're working with physicians who, in many cases, have been



1 20 years working under a pre-payment system and suddenly  
2 have to learn something that was learned very early on by  
3 physicians in fee-for-service, it turns out to be very  
4 difficult to do.

5           So again without gainsaying the reasons why the  
6 decisions was made, the fact it was made created for our  
7 organization and others an opportunity to try to get to the  
8 even playing field by teaching our physicians over time the  
9 reality of the coding world, which in fact physicians who  
10 are paid on fee-for-service have known for a long time.

11           That process is not completed yet, and I guess I  
12 would say there are a number of people in my own  
13 organization and others who are currently breathing into  
14 paper bags as we have this discussion because of a concern  
15 that more time is needed. And in order to get to that even  
16 playing field that we say we want, that's an important  
17 consideration.

18           MR. HACKBARTH: To the extent that a group of  
19 providers like yours are less used to, experienced with  
20 coding, the potential consequence of that is that when we  
21 compare patients they look healthier than, in fact, they are  
22 because all of the comorbidities, et cetera, haven't been

1 completely coded.

2           And so if you give more time, your argument is  
3 that you may actually find what looks like a very good  
4 selection of risk. The difference between your selection  
5 and Medicare's shrinks and it has nothing to do with the  
6 changing population but simply proficiency in coding, if  
7 I've properly summarized it.

8           DR. CROSSON: That's correct.

9           MR. MULLER: [off microphone.] Help me understand  
10 the reweighting. Everything now is comorbidity and so  
11 therefore it's a more [inaudible]. How is the reweighting  
12 of that [inaudible].

13           DR. BERTKO: I'm not sure of the DRGs, but Dan  
14 alluded to something. There are now going to be 30 more  
15 diagnoses, roughly, added to the risk adjustment system.  
16 That makes the pencil sharper. And so yet more diagnoses  
17 will be there and those predictive ratios, if anything,  
18 should get better over time.

19           That is, we predict more about more diseases, the  
20 healthy baseline actually falls, and you begin sending money  
21 out to various people in more disease categories.

22           MR. HACKBARTH: But the way this is currently

1 being done, if I understand correctly, we're using those  
2 potentially flawed understated numbers to redistribute  
3 dollars within the pool, but in the aggregate holding plans  
4 harmless.

5 DR. BERTKO: Yes.

6 MR. HACKBARTH: So all health plans, that dollar  
7 pool is fixed but you might be getting more or less. For  
8 example, as a staff model group model HMO with less  
9 proficient coders, be getting less money relative to John's,  
10 who's using fee-for-service providers who are very  
11 proficient at it.

12 DR. BERTKO: There is actually a different  
13 element, in addition to the coding, is the data collection.  
14 Those of us who were awake at the start of this, and two of  
15 us are in the room, are doing better and have a fairly good  
16 incentive to both code and collect and submit data well.

17 MS. DePARLE: Actually three of us and maybe  
18 another one, including Mark. What I remember at the  
19 beginning, remember risk adjustment was supposed to have  
20 been fully phased in five or six years ago. And at the  
21 beginning, the plan said that they couldn't collect the  
22 data. So my concern about all of this is that it just seems

1 to be taking forever to get to what everyone says they agree  
2 to, which is a level playing field.

3 DR. BERTKO: May I make my other comments now,  
4 switching gears.

5 This goes back to the area buttons, and I'll take  
6 Bob at his metaphor, and I would ask him and collectively  
7 us, to hold your finger above the button but not push it for  
8 a couple of reasons yet.

9 The first it is, and this is both sides, the plan  
10 side for MMA and the CMS side. There is a huge amount of  
11 change, and thus uncertainty, flowing through the system  
12 starting 1/1/06, including regional PPOs and all kinds of  
13 stuff in the bidding.

14 One of the questions that I'm sure we will want to  
15 ask is what happened? And to introduce new geographic areas  
16 on top of everything else immediately would confound that.  
17 So I would say have some patience a little bit here again.

18 Point number two, and I know this makes it yet  
19 more complex, is I would encourage Dan at least, who I think  
20 is thinking about this quite a little bit, to consider the  
21 very large urban MSAs. And there's three of us from the Bay  
22 Area here. Jay, who lives on the peninsula, I believe.

1 Arnie, do you live in Mill Valley? In the city. And I live  
2 there, in Oakland. And none of us ever cross over. Alameda  
3 County is a huge county, possibly bigger than some East  
4 Coast states with a million people in it. And having a  
5 single metropolitan MSA for an area as big as this, or say  
6 New York City's five boroughs together, might be not the  
7 best thing in the world either because the delivery systems  
8 are just very difficult.

9 I have one more comment after that. The third is,  
10 and again this could be a reason to push or not push the  
11 button, effectively post-MMA if regional PPOs spring into  
12 existence the worry about rural payment areas may become  
13 moot because it will be boom, the state of Texas, the state  
14 of California, the state of Florida, or even bigger multi-  
15 state regions.

16 In which case -- and Sarah alluded to this --  
17 there is a highly complicated interservice area region  
18 adjustment that I don't even think I quite understand yet  
19 myself. So put that on board and say patience, perhaps.

20 DR. ZABINSKI: On your issue of the size of some  
21 of the MSAs, I know in the Bay Area there's actually quite a  
22 few MSAs. I mean, San Francisco and Oakland are in separate

1 MSAs. They aren't that big. And they would serve as  
2 distinct separate payment areas. Contra Costa and Alameda  
3 make up the Oakland MSA. And San Francisco, San Mateo and  
4 Marin County make up the San Francisco MSA. By looking at  
5 it the areas that are covered by plans, they match those  
6 MSAs pretty well.

7 I'm not as concerned about that as you are.

8 DR. BERTKO: I stand corrected. I usually think  
9 of the MSAs as they are in kind of the USA Today maps.

10 DR. WOLTER: I was just thinking that in the  
11 quality section there might be an opportunity. I think over  
12 time one of the interesting questions will be how do  
13 incentives work at a plan level versus at a provider level.  
14 If you were to take group practices or take some of the  
15 informal but natural collections of physicians and hospitals  
16 that Arnie was talking about, is there a way to slice and  
17 dice the quality comparisons a little bit more finely rather  
18 than global fee-for-service versus global plan?

19 And even within plans, there are plans that are  
20 very tied to group practice and staff models and others that  
21 are very tied to more independent practice setups.

22 If there were any way in the text to suggest that

1 some analysis along those lines could have value, I think we  
2 might learn quite a bit more than just looking globally at  
3 fee-for-service versus the plans.

4 DR. REISCHAUER: With respect to John's hold your  
5 finger off the button, there's an awful lot of things where  
6 I think we need to prioritize and say this is the objective  
7 over the longer run. You have an awful lot of work going on  
8 and there's chaos in the sector, and all of that. And we  
9 want change to be in an orderly way.

10 With respect to the risk adjustment  
11 recommendation, I'm wondering whether we aren't beating a  
12 dead horse here. The budget says that starting in 2007 they  
13 will wring this excess payment out over a number of years.  
14 And Jay is saying a lot of this has to do with stability,  
15 having change occur in an orderly process. We can get all  
16 carried away with our recommendation was level playing  
17 field, we want level playing field, do it yesterday.

18 But maybe what we need to do is pat the president  
19 on the back and say stick with it, don't back off when Jay  
20 and John come at you and try and get you to postpone it, the  
21 way they've done for the last six or seven years, as Nancy  
22 points out.

1           With respect to the hospice issue, I think you  
2 make a convincing case in the best of all worlds why this is  
3 really reintegrating it into the managed-care plan is ripe.  
4 But I wonder if some of the original reluctance which was  
5 alluded to didn't have to do with a fear that managed-care  
6 plans paid in a capitated manner might encourage or market  
7 hospice more aggressively than was appropriate because there  
8 was huge savings for them to be realized by this.

9           Now of course, the latest data seems to show that  
10 hospice, on average, costs money. I'm not sure that would  
11 be true in this kind of setting. But anyway, I think it's  
12 an issue that we have to at least pay some attention to.

13           MS. BURKE: That was my point, is I want to be  
14 certain that we fully understand the implications in a  
15 managed-care environment. In '83, it wasn't even an issue  
16 of the managed-care world. So the anxieties at that time  
17 were far more related to our failure to really understand at  
18 that time what hospice meant and how one provided it and  
19 from whom it would be provided.

20           But I think the most recent issue is, in fact, one  
21 of is it conceptually consistent with or is it at risk in a  
22 managed-care environment where there is a great incentive to



1 reduce costs?

2 That's exactly my point, is I want to be sure we  
3 fully appreciate what the risks are. And are there any  
4 examples out there that we ought to look at where, in fact,  
5 it's been successfully integrated or part of a managed  
6 system. See you're exactly right, Bob.

7 MS. THOMAS: One of the interesting things is last  
8 year I did an analysis of looking at the utilization rate of  
9 hospice in managed-care. In the current fee-for-service  
10 arrangement, actually you use higher use of the hospice by  
11 managed-care companies. But there's actually quite a lot of  
12 variation by plan in that.

13 I also can bring back some descriptions of some of  
14 the companies out there offering plans have done some really  
15 innovative things. Aetna, in fact, has looked at creative  
16 ways of looking at a more continuum of care and providing  
17 more palliative care earlier on and not creating -- so there  
18 are models out there. Obviously, without the incentives in  
19 Medicare to create those models, that does cut out some of  
20 that innovation.

21 MR. SMITH: Briefly, Glenn, on two possible  
22 recommendations that we haven't talked about because of our

1 map fascination. And I have a map question I want to ask  
2 you when we get done.

3 On the payment issue, Sarah, the bonus payments  
4 that you refer to in the possibility of a recommendation,  
5 that's the stabilization fund?

6 MS. THOMAS: Yes.

7 MR. SMITH: And a slightly unfair  
8 characterization, but I'd just like to test it. This is a  
9 if it doesn't work we'll throw \$10 billion at it?

10 MS. THOMAS: Yes.

11 MR. SMITH: I think we ought to see if we can't  
12 turn that into a recommendation.

13 The essential hospital provision, a question. Why  
14 wouldn't you refuse to contract with a plan so that you  
15 could get in the queue to get the additional pay? It seems  
16 to me it's an invitation not to make a deal.

17 But then there's no money to support it. So it  
18 had the feel of one of these provisions that for a place  
19 located at the following geographic coordinates, made out of  
20 brick, we will provide a tax break if...

21 But unless there's something I'm missing, it seems  
22 to me a \$25 million pot that invites people to behave badly

1 seems goofy on both counts. And we ought to make a  
2 recommendation in that regard.

3 MR. HACKBARTH: It's one that falls less under the  
4 category of dangerous than just sort of silly.

5 DR. MILSTEIN: A couple of brief comments on the  
6 quality provisions.

7 First, due to the constraints that we faced around  
8 budget neutrality, we recommended P4P for a variety of  
9 providers that was powered by a size of incentive that in  
10 the initial years nobody believed is going to be enough to  
11 induce fundamental reengineering of anybody's practice or  
12 hospital.

13 One way we can begin to offset that deficit would  
14 be in the quality incentive rules that we ask of Medicare  
15 Advantage plans of all types. We have a problem that I've  
16 referred to repeatedly as sub-therapeutic dose of P4P  
17 quality incentives. Can we at least, with respect to the  
18 Medicare Advantage component of Medicare, encourage that the  
19 Medicare Advantage plans use the same quality measures as  
20 their basis of provider P4P? That's idea number one.

21 Idea number two relates to the fact that our  
22 current suite of quality measures for plans is pretty good,

1 thanks mainly to the work of NCQA. But it remains spotty.  
2 If you look at that suite of quality measures denominated  
3 against anything that a scientist would consider to be a  
4 robust measure of what's really going on in doctor's offices  
5 and in hospitals, it remains quite thin.

6           And so I wanted to also ask that maybe we consider  
7 adding the Health of Seniors Longitudinal Survey of Physical  
8 and Mental Status as one of the requirements for all  
9 Medicare Advantage plans. The survey is cheap, it does a  
10 beautiful job of offset gaming risk because you're measuring  
11 longitudinal change in physical and mental status of a  
12 population that's enrolled in a plan. And I think it  
13 fundamentally best captures why beneficiaries are buying  
14 health care in the first place. It's to maximize their  
15 number of disability-free life years.

16           MS. THOMAS: I'm under the impression that most  
17 types of plans do provide Health of Seniors data.

18           DR. MILSTEIN: We have an opportunity here, for  
19 example in the PPO part of Medicare, to institute it. And  
20 also, for reasons that remain murky, the equivalent number  
21 or the equivalent measure that Health of Seniors, we are no  
22 longer applying it to the fee-for-service population. I

1 think it's a very helpful benchmark to have when we're  
2 trying to, at some future date, the judge the effect of  
3 these various types of plans compared to the fee-for-service  
4 baseline.

5 DR. CROSSON: I had just asked the question  
6 earlier about the reason for not having dual state MSAs?

7 DR. ZABINSKI: Our basis for that idea is that the  
8 insurance laws, rules and guidelines differ between states.  
9 What I found when looking at an MSA that's partly in one  
10 state and partly in another, the plans that serve different  
11 states are often very different plans.

12 Philadelphia is one that really comes to mind.  
13 The plans that serve the Pennsylvania part of that MSA are  
14 very different than the ones that serve the New Jersey part  
15 of the MSA.

16 So our thinking was that requiring a plan to serve  
17 that entire MSA would put, I don't know, an additional  
18 burden on top of them that may make serving the MSA  
19 unattractive altogether.

20 MR. HACKBARTH: Under the prevailing rules, if you  
21 have a two-state MSA and it's treated as one service area,  
22 they would have to be licensed in both states. And that's

1 potentially a barrier. That was my thinking about it.

2 Now if they want to do that, that's fine. But to  
3 require it is one of those thresholds that just makes it  
4 more difficult to get people into the program

5 Okay, let's turn to our public comment period,  
6 with the usual ground rules, brief comments.

7 That's just the right length.

8 MR. HACKBARTH: Thank you very much. We're going  
9 to adjourn for launch until 1:45.

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

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1 to another.

2           For our June report this year, we plan to examine  
3 additional issues related to the implementation of the  
4 benefit. Our goal is to enable MedPAC to have the tools  
5 necessary to evaluate how the drug benefit is working in  
6 2006.

7           There are three ongoing projects for this chapter.  
8 This morning Rachel presented our work on geographic  
9 variation in drug spending. I will presenting some interim  
10 findings from our interviews of stakeholders on how  
11 formulary exceptions and appeals processes work in the  
12 commercial market and Medicaid.

13           In April, we'll be presenting the results of an  
14 expert panel gathered to discuss possible performance  
15 measures for monitoring the prescription drug benefit.

16           The MMA permits plans to use tools developed in  
17 the private sector, like formularies and tiered copayments,  
18 to manage drug utilization and help control costs. It also  
19 puts in place an appeals process to ensure that  
20 beneficiaries have access to needed drugs. The way in which  
21 the appeals process is implemented will help ensure that the  
22 goals, sometimes competing goals, of controlling costs,



1 maintaining access and ensuring the quality of the benefit  
2 are realized.

3           Because of the importance of this issue, we set  
4 out to find out how the processes currently work in private  
5 plans and in Medicaid. We've been interviewing physicians,  
6 pharmacists, consumer advocates and representatives from  
7 health plans and pharmacy benefit managers.

8           The MMA permits plans to use closed formularies  
9 where they limit the number of drugs covered in a particular  
10 therapeutic class. If a physician decides that a patient  
11 needs an excluded drug, they would ask for a formulary  
12 exception. Or, as is more commonly the case today, plans  
13 may cover more drugs but ask members to pay higher cost  
14 sharing if their prescription is for a non-preferred drug in  
15 the class. In some cases, physicians must also get prior  
16 approval before non-preferred drugs are covered. These  
17 processes are handled in the same way, both the exceptions  
18 and the prior authorization. So for convenience, I'm just  
19 going to be describing one process, which I'll refer to as  
20 prior authorization.

21           One of the first questions that we asked our  
22 interviewees was why a plan would place a drug on prior

1 authorization. This is a list of some of the most common  
2 questions that we heard. But the actual content of the  
3 interviews were really interesting and different. One plan  
4 representative described requiring prior authorization for  
5 all non-sedating antihistamines after one product in this  
6 class became available over-the-counter. In order for  
7 members to receive coverage for one of these drugs now,  
8 their physician had to document that the over-the-counter  
9 product had not controlled their allergy, a process known as  
10 step therapy.

11 Our interviewee said that they had to hire six new  
12 employees to handle all the calls that came in looking for  
13 exceptions for this rule but the plan calculated that it  
14 saved \$10 million on this one decision alone.

15 Another example, and this one we heard from quite  
16 a number of people, was the case of human growth hormone.  
17 This is a product that has medically important uses but is  
18 also something that you may, in fact, read about in the  
19 newspapers that athletes sometimes use, particularly body  
20 builders. Plans wanted to be make certain that they cover  
21 the drug for the medically appropriate reasons but not cover  
22 it for body builders, for example. So this was something

1 that pretty nearly every plan told us was on prior  
2 authorization.

3           One interviewee said that prior authorization was  
4 worth doing even if almost all of the requests were approved  
5 because when a physician was notified by the pharmacy that  
6 the requested drug was not covered but that another was, the  
7 physician often agreed to use the preferred drug without  
8 ever asking for an exception. I also need to make the point  
9 that prior authorization is used very frequently in Medicaid  
10 because it is the main tool that Medicaid has to manage  
11 their drug benefit.

12           We then asked our interviewees to describe the  
13 process and we heard a very similar scenario in each case.  
14 Ideally, prior authorization should happen before the  
15 prescription is written but, in fact, often doesn't.  
16 Physicians frequently don't know what drugs are on their  
17 patients formularies or require prior authorization, so the  
18 patient may first become aware of the need for prior  
19 authorization when they take their prescription to the  
20 pharmacy and the pharmacist tries to process the  
21 prescription and gets a notice saying either the drug  
22 requires prior authorization or the drug is not covered but

1 lists other drugs that would be covered for the same  
2 condition.

3           The pharmacists will then usually contact the  
4 physician. At this point, when the physician is reached,  
5 they may either change the prescription to the alternate  
6 covered drug or else they will contact the plan call center  
7 and request approval. Every plan has a call center that  
8 gets requests from plans. Plan employees have written  
9 protocols that tell them what information is needed and what  
10 the answer should be in order to grant an approval.

11           The call center can either approve the request or,  
12 in most cases, the call center will not disapprove a request  
13 but if the request doesn't meet the criteria they will send  
14 it to a plan pharmacist or a plan physician. If the plan  
15 physician continues to think that the drug is not medically  
16 appropriate, it will either go to another pharmacist or  
17 physician within the plan or sometimes to an external  
18 reviewer.

19           If, after this two or three stage process, the  
20 person has still not gotten the request approved and the  
21 physician still thinks it's important, then the request  
22 would be appealed and it would go to the plan's customer

1 service department for a formal appeal. We heard  
2 universally that this was very uncommon.

3           Although our interviewees described very similar  
4 processes, they also reported very different strategies in  
5 terms of the number and types of drugs that they restricted.  
6 Most plans did say that they will usually give exceptions if  
7 they receive all of the necessary medical documentation.  
8 Plans also report that right now they have to meet many  
9 different kinds of compliance standards about their  
10 processes and time frames for handling requests. These  
11 standards would differ based upon the payer mix that they  
12 have and also what states the plans are located in. For  
13 example, some states say that only physicians can reject  
14 requests.

15           Plans tend to keep very detailed information on  
16 what happens to exceptions requests when they come into the  
17 call center. If they get many requests for a particular  
18 drug, they often will refer that drug to their P&T Committee  
19 to see if they should change their formulary.

20           On the other hand, some information never comes  
21 back to the plan. They never are able to collect it. For  
22 example, they don't know how often a beneficiary at the

1 pharmacy counter pays out-of-pocket for a drug when told  
2 their plan won't cover it or goes without the medicine.  
3 They also don't know how often a pharmacist contacts a  
4 physician or instead tells the plan member that their drug  
5 isn't covered. And they also don't know if a physician who  
6 has been contacted does not have the time to respond.

7           However as I said before, few drugs go to formal  
8 appeals.

9           All of the plans agreed that this whole process  
10 can create a burden for both beneficiaries and providers in  
11 terms of time and money. One physician told us that for his  
12 practice he has two call nurses that each spend about an  
13 hour a day simply handling prior authorizations.

14           On the other hand, plans try to minimize this  
15 burden in a number of ways. One is they try to educate both  
16 plan members and physicians about what's in their  
17 formularies. The second thing is notification. Plans told  
18 us that every time a request would not go through in the  
19 pharmacy, the member would receive a notice telling them why  
20 the prescription could not be filled and frequently giving  
21 them the names of other drugs that would be covered and  
22 telling them to ask their physicians about them.

1           Some plans have automated as much of the process  
2 as possible. So for example, if a plan has one ace  
3 inhibitor that is their preferred drug, they will have  
4 automated into the system if a patient has already taken  
5 that drug and it didn't work for them, they see that there  
6 has been a scrip for the preferred drug, when another  
7 prescription comes for a non-preferred drug, it would go  
8 through seamlessly without anybody having to ask for prior  
9 authorization.

10           Some plans choose to deal with the burden issue by  
11 simply placing fewer drugs on prior authorization and using  
12 the difference in cost sharing between preferred drugs and  
13 non-preferred drugs as their main way of steering people  
14 towards the preferred products.

15           CMS regulations on appeals generally support the  
16 processes that plans described to us. There were some  
17 differences however.

18           DR. NELSON: Joan, did you get a sense from the  
19 plans about how many drugs would be on a prior authorization  
20 list on a typical plan, whether it be 10 drugs that are  
21 commonly prescribed or whether it would be just a number of  
22 the far out drugs? It seems like how big of a burden it

1 would be would be related to how many drugs a physician had  
2 to remember were on prior authorization and whether a few  
3 common drugs that they prescribe all the time, where there  
4 was only one drug in that class for example, that they knew  
5 would pass.

6 DR. SOKOLOVSKY: It seemed to be all over the  
7 place and that is a question that we asked and we got every  
8 which kind of answer. The physicians said the main problem  
9 was they don't tend to deal with just one plan so  
10 remembering the formulary of one plan wouldn't translate to  
11 remembering the formulary of another plan.

12 DR. NELSON: Of course, and that's the reason why  
13 the problem would be obviously compounded by the number of  
14 plans. But if there were a relatively small number of  
15 drugs, in the first instance, it would be geometrically  
16 less.

17 DR. SOKOLOVSKY: I was trying to look for a  
18 pattern there and I couldn't find one.

19 In talking about some of the differences in the  
20 CMS regs compared to what we heard, plans must develop a  
21 transition policy for new members who are already on a  
22 particular drug that is not covered on their new plan's



1 formulary. This is an issue that has been mentioned as  
2 being very important to dual eligibles who would transfer  
3 from Medicaid to Medicare. CMS has not yet issued  
4 guidelines on what the transition policy should look like  
5 but we did hear from many plans that they already had  
6 informal processes in place to handle this situation.

7 Another difference is that more things are  
8 considered coverage determinations and may be appealed.  
9 This would include not only decisions concerning exception  
10 requests but also, under the MMA, beneficiaries can appeal  
11 the copayments. If they get a drug that is a non-preferred  
12 drug and has a higher cost sharing, they can appeal to get  
13 the preferred drug cost sharing level. And that is  
14 something that plans told us they had very little experience  
15 with.

16 Network pharmacies also must post notices or  
17 distribute forms telling beneficiaries how to request  
18 exceptions or repeal coverage determinations for every plan  
19 to which they are a network pharmacy.

20 Another difference is that the time frame for  
21 handling exceptions requests is quicker under the MMA. For  
22 an urgent request for an exception, plan must handle the

1 determination after they receive all of the necessary  
2 documentation within 24 hours. That was typically faster  
3 than we were told was a requirement for most plans now.

4 I haven't said much about grievances. It didn't  
5 come up very much. The terminology was pretty much  
6 different. But a grievance under the regulations is not a  
7 coverage determination but rather a problem with how a  
8 member is treated. Grievances are handled internally within  
9 a plan but the plan must have a process for handling them  
10 and make that process known.

11 There are some factors that may lead to an  
12 increased volume of appeals, and I've mentioned some of  
13 them. For example, the ability to appeal copays and to have  
14 shorter expedited time frames. This is something that could  
15 be an issue under Part D if increased volume becomes a  
16 significant expense for plans. Premiums could rise if plans  
17 put fewer restrictions, except for tiered cost sharing, on  
18 non-preferred drugs in order to minimize the number of  
19 appeals that they have to deal with. Or premiums could rise  
20 if plans have to pay the added expense of dealing with a  
21 higher volume of appeals.

22 Good communication is going to be very important

1 to prevent this and one thing that everyone agreed upon was  
2 that the development of e-prescribing and the prescription  
3 of that technology will be very important in dealing with  
4 this issue. The MMA includes a number of incentives to  
5 support e-prescribing.

6 One interviewee raised the question about how the  
7 structure of the standard benefit might influence the prior  
8 authorization process. Beneficiaries, you may remember,  
9 will have to pay 100 percent cost sharing for spending  
10 that's below the deductible and above the initial benefit  
11 level. Plan members might not like going through an  
12 exceptions process and then paying 100 percent of the cost  
13 of the drug if they get the exception. But if they pay out-  
14 of-pocket without going through the process, then payments  
15 wouldn't count towards the out-of-pocket limit.

16 Another issue that's getting a lot of attention is  
17 the difference between the Medicare regulations and the  
18 Medicaid appeals process. Under Medicaid beneficiaries are  
19 entitled to what's called a predetermination hearing before  
20 ongoing drug treatment can be ended or reduced. The program  
21 has to, in other words, continue providing the benefit until  
22 a hearing to determine the result of that request. Dual

1 eligibles will not have this right under Medicare. However,  
2 when we spoke to Medicaid plans and we spoke to beneficiary  
3 advocates, they reported very few drug-related appeals under  
4 Medicaid right now. But this is something that we need to  
5 watch.

6 Another issue that came up was the question of  
7 whether appeals and grievances should be publicly reported.  
8 This is very important to beneficiary advocates and  
9 representatives from plans and PBMs were mixed on the issue.  
10 Some of them wanted them publicly reported but others were  
11 afraid that since their strategies for prior authorizations  
12 were so different that reporting would be comparing apples  
13 and oranges.

14 As with other aspects of Part D, it's going to  
15 take some time to see how any of these issues are going to  
16 play out but I'll be happy to take any of your questions or  
17 suggestions now.

18 MR. HACKBARTH: Questions, comments?

19 DR. REISCHAUER: Just one little comment on your  
20 description of how a beneficiary might be irritated if they  
21 went through a prior authorization and then had to pay 100  
22 percent of the drug because they were in the doughnut hole.

1 Of course, they'll be buying the drug, in a sense, at a  
2 discounted price which should be lower than the out-of-  
3 pocket price for somebody just walking in. And that will be  
4 20 percent lower or something like that. So there still is  
5 some incentive, although not huge.

6 DR. BERTKO: May I add, there's a big policy  
7 incentive because 80 percent of the amount above the  
8 doughnut hole is paid for by the feds. So having the right  
9 drug at the right price is reasonably important.

10 MS. BURKE: Can I ask a clarification of Bob's  
11 question? Is it, in fact, assumed or is it, in fact,  
12 required that the extent to which someone is securing  
13 coverage for a drug that the plan won't cover at that point,  
14 it's an approved drug but it is one that they are within the  
15 doughnut hole, do we assume that they get the discount?

16 DR. SOKOLOVSKY: It's more than assumed. The law  
17 requires it.

18 MS. BURKE: That the discount applies at that  
19 point?

20 DR. BERTKO: Yes.

21 DR. SOKOLOVSKY: Yes.

22 DR. REISCHAUER: But there has to be a price at

1 which the plan can put into the calculation of the amount  
2 you've spent towards the catastrophic.

3 MR. HACKBARTH: Any others? Okay. Thank you,  
4 Joan.

5 Next up is Medigap and cost sharing.

6 DR. BERNSTEIN: Today we'd like to start a  
7 discussion about beneficiary cost sharing and private  
8 individually purchased supplemental insurance, Medigap, in  
9 light of changes introduced by the Medicare Modernization  
10 Act.

11 The materials we put together draw on a number of  
12 recent MedPAC reports and some new analysis of some Medigap  
13 data. Sarah Kwon will summarize what we know about the  
14 Medigap policies and I will describe some policy issues and  
15 seek your input on three possible directions for future  
16 work.

17 The topics, briefly, are improving information on  
18 insurance options, policy directions for cost sharing and  
19 first dollar coverage, and the potential role of Medigap  
20 models in broader Medicare payment reform.

21 MS. KWON: I will begin by briefly reviewing the  
22 basic characteristics of Medigap. Medigap provides

1 supplemental insurance coverage to approximately 10 million  
2 Medicare beneficiaries. This constitutes a little over a  
3 quarter of non-institutionalized beneficiaries.

4 Medigap offers 10 standardized plans, A through J.  
5 All cover Part A hospital coinsurance and Part B  
6 coinsurance.

7 The distribution of beneficiaries among plans has  
8 remained stable over time. Plans F and C, which cover most  
9 of Medicare's cost sharing, are the most popular plans.  
10 Plans H, I and J, which cover prescription drugs, have never  
11 been popular and will not be sold after 2006.

12 It is important to note two variants of these  
13 standard plans that are not shown here on this chart. The  
14 first is SELECT plans. These are Medigap plans that cover  
15 more cost sharing when beneficiaries use network providers.  
16 They generally have lower premiums than comparable Medigap  
17 plans.

18 According to our analysis of 2003 Medigap data  
19 from the National Association of Insurance Commissioners,  
20 approximately 1.2 million beneficiaries are enrolled in  
21 SELECT plans. They are concentrated in a small number of  
22 markets.

1           The second variant is high deductible plans. This  
2 option is offered through F and J plans. High deductible F  
3 and J plans offer the same benefits as regular F and J plans  
4 except beneficiaries must pay a high deductible before the  
5 plan covers benefits.

6           In 2003 the standard deductible was \$1,650. NAIC  
7 data shows that less than 10,000 beneficiaries purchased  
8 high deductible F plans in 2003. We were unable to identify  
9 any high deductible J plans in the NAIC data although we  
10 know they exist. High deductible plans are rare but there  
11 are some areas where they are heavily marketed.

12           Some SELECT and high deductible plans offer  
13 innovative benefits such as case management and smoking  
14 cessation. For both the SELECT and high deductible plans,  
15 our figures for the number of covered lives are incomplete  
16 because some plans do not report to NAIC.

17           As this table shows, average monthly premiums  
18 exceed \$100 for most plan types. For plans C and F, the  
19 average monthly premium is approximately \$130, which means  
20 that beneficiaries must pay approximately \$1,600 in premiums  
21 per year. This upward trend in Medigap premiums is  
22 correlated to the upward trend in Medicare spending. In the



1 same period depicted on this table, total Medicare  
2 expenditures per enrollee increased by almost 11 percent.

3           It is important to note that there is a lot of  
4 variation of premiums within and across markets. Weiss  
5 Ratings, Incorporated found that in 2004, the average  
6 national premium for a 65-year-old female enrolled in Plan C  
7 was \$1,689 nationally. But across different markets, it  
8 varied from \$616 to \$6,271.

9           DR. BERNSTEIN: The new drug benefit created by  
10 the MMA involved some structural changes to Medigap. As  
11 Sarah noted, there will be no new H, I or J policies sold  
12 after January 1, 2006. The law also introduced two new  
13 policies, K and L. Both of these policies require the  
14 beneficiary pay the Part B deductible and both the policies  
15 cover all catastrophic hospital costs after a year.

16           Plan K covers half of the applicable coinsurance,  
17 beneficiaries have a cap of \$4,000. L covers 75 percent of  
18 the applicable cost sharing up to a \$2,000 out-of-pocket  
19 limit.

20           These limits are going to be indexed to inflation  
21 using an adjuster specified by the Secretary of HHS. I  
22 would also note that plans don't cover excess charges or

1 balanced billing.

2           The law and accompanying conference report to the  
3 MMA also asked NAIC to do two things. First, they had to  
4 revise the model regulation for Medigap to accommodate the  
5 new policies and to deal with the phasing out of the  
6 existing policies and included drug benefit. That work is  
7 completed and states and insurers can begin to operate under  
8 the new rules as soon as the states incorporate the new  
9 model regulation into their own state policies.

10           In addition, Congress asked NAIC to think more  
11 broadly about ways to restructure Medigap. I will read this  
12 verbatim. They were asked to "consider broader changes to  
13 the Medigap market that will effectuate reduced premiums and  
14 more rational coverage policies that create incentives for  
15 appropriate utilization of services."

16           The discussion in the conference report mentioned  
17 in particular concerns about first dollar coverage for  
18 Medicare covered services. NAIC is beginning to work and  
19 this broader charge. In fact, they're having a meeting that  
20 starts tomorrow where the committee working on this will  
21 begin their deliberations in earnest.

22           Your mailing materials review a variety of

1 findings and conclusions about supplemental coverage.  
2 Briefly, previous MedPAC reports, as well as recent analysis  
3 by our staff and other researchers, has consistently shown  
4 that first people with supplemental coverage spend more on  
5 health care and use more Medicare services than people who  
6 do not have supplemental coverage.

7           And second, that people with Medigap use more  
8 Medicare services than people with employer based  
9 supplementation. This holds true when we control for, to  
10 the extent possible, health status, income and other  
11 demographic factors. The research is not able to clearly  
12 identify how much of this additional use of services for  
13 those with Medigap is for services that are unnecessary or  
14 of questionable value versus appropriate use of care that  
15 might be obtained of beneficiaries were exposed to  
16 significant cost sharing.

17           There is some research that indicates that  
18 beneficiaries without supplemental coverage report more  
19 access problems and are more likely to not receive  
20 recommended services such as preventive care or other  
21 technical things.

22           Other research shows that seniors without drug

1 coverage are less likely to purchase or take prescribed  
2 drugs. However, because they use more health services, on  
3 average, than most other beneficiaries, only Medicaid duals  
4 use more, and also because they have very little coverage  
5 for services Medicare doesn't cover, people with Medigap  
6 spend more out-of-pocket counting premiums than other  
7 beneficiaries. Uncovered services include, under most  
8 Medigap policies, prescription drugs but also things like  
9 hearing, dental and vision care and some mental health  
10 services that Medicare does not cover or cover well.

11 Over the past decade or so, a growing proportion  
12 of beneficiaries' out-of-pocket spending has been for  
13 prescription drugs. So it's difficult to predict how out-  
14 of-pocket liability for people with Medigap will compare to  
15 other beneficiaries after 2006 when the Part D benefit comes  
16 online.

17 There is substantial agreement that the Omnibus  
18 Budget Reconciliation Act reforms that led to the  
19 standardization of Medigap policies and established national  
20 oversight and consumer protection requirements were  
21 successful in stabilizing the Medigap market. Medigap is  
22 quite popular with beneficiaries. It eliminated much of the

1 paperwork at the doctor's office and beneficiaries appear to  
2 play significant value on the predictability of paying  
3 premiums rather than having to deal with the costs of  
4 medical care as it arises.

5           State regulators enjoy the stability of the  
6 current market and the fact that they see very few  
7 complaints from consumers about Medigap. But there are also  
8 some basic problems with Medigap, many of which we have  
9 discussed in various contexts and reports over the last  
10 couple of years. Medigap is expensive. There's not a whole  
11 lot of competition in many local markets. Some of the  
12 standard benefits no longer make a lot of sense from an  
13 insurance perspective. NAIC will likely address these sorts  
14 of issues in depth.

15           There are also even larger so-called level playing  
16 field issues. Medigap is a very different form of coverage  
17 than other Medicare options it competes against. Not all  
18 beneficiaries have access to affordable Medigap plans.  
19 Although there are federal minimum standards for open  
20 enrollment and guaranteed issue for people age 65 and older,  
21 there are some significant differences in enrollment and  
22 rating or underwriting rules across the states. Some of the

1 more basic aspects of federal regulation are likely beyond  
2 the scope of the issues that the NAIC will be addressing but  
3 they are part of the bigger set of issues surrounding  
4 competition among the Medicare options.

5           The first of the Medigap issues the Commission  
6 might want to explore follows directly from work we  
7 completed late last year related to devising ways to help  
8 beneficiaries understand and make choices among coverage  
9 options. We divided this into two parts, getting  
10 information from Medicare plans, the first sub-bullet, and  
11 getting that information to beneficiaries, the second sub-  
12 bullet.

13           As we've noted, information on what is actually  
14 available in local Medicare markets is sometimes incomplete  
15 or insufficiently detailed. There are some technical issues  
16 here but we believe that some changes in reporting and  
17 oversight requirements would help the states and CMS, and in  
18 turn beneficiaries, get a better view of Medigap options and  
19 how they compare to MA and drug plan options. With better  
20 data, there may be way CMS can augment the information it  
21 makes available on the Medicare Personal Plan Finder or in  
22 other software that might be useful in one on one counseling

1 with beneficiaries.

2 A second topic that we are already working on is  
3 refining our understanding of how cost sharing and out-of-  
4 pocket spending affects the use of services and Medicare  
5 costs. This includes analyzing policy issues as well as the  
6 available literature on cost sharing, particularly in older  
7 populations.

8 We're also updating some of the analysis that  
9 we've done before using newer data available from MCBS.  
10 This analysis could support the development of general or  
11 perhaps more specific guidance that the Commission might  
12 want to offer the NAIC regarding cost sharing and first  
13 dollar coverage in Medigap.

14 Finally, we've identified for discussion one topic  
15 that brings us closer to broader considerations in the  
16 payment for fee-for-service Medicare. Current law and  
17 regulations grant insurers a great deal of flexibility in  
18 establishing preferred provider networks for Medicare SELECT  
19 plans, both in terms of creating networks and structuring  
20 cost sharing for particular SELECT products. There are some  
21 natural experiments in some local markets, such as the  
22 SELECT model in Minnesota that we described in last year's

1 report on market variation, that might help in  
2 conceptualizing ways to reap some of the benefits of care  
3 management in a fee-for-service environment.

4 The Commission may want to explore whether new  
5 standards or model regulations for SELECT plans or for other  
6 Medigap products could provide a mechanism for creating  
7 networks or tiers of fee-for-service Medicare providers  
8 based on accepted measures of quality and efficiency.

9 We look forward to hearing your comments on  
10 priorities for work on Medigap, both in terms of the NAIC's  
11 work and more broadly in terms of cost sharing and Medicare  
12 payment reforms.

13 DR. BERTKO: A couple of points. First, a good  
14 report. I think pretty thorough. I would just point out to  
15 my fellow commissioners, Jill zoomed past two parts which I  
16 think are fairly important. The first is on the average  
17 premium comparison, which strikes me as being accurate. But  
18 I believe in most states reflecting an attained age premium.  
19 So a 67-year-old might pay \$70. A 77-year-old might pay  
20 \$150. And an 82-year-old might pay considerably more.

21 Which leads to -- I won't say it's a  
22 recommendation. but just for us to consider. There are a



1 few community rated states. Medicare Advantage plans are  
2 all community rated. And in the interest, which I think is  
3 very positive here, of helping seniors compare one to the  
4 other, do we want to have any consideration of suggesting  
5 community rating as one of the alternatives? Because all of  
6 a sudden everything is on a more level playing field.

7           The other thing is, again zooming past it, was the  
8 enrollment features. Some, maybe most of the plan options,  
9 are only available in the six-month period after you turn 65  
10 or after you retire from being actively at work. Which  
11 again, is completely different from what's going to be the  
12 annual open enrollment period for Medicare Advantage plans.

13           This is actually a two-way street. If you have  
14 somebody that chooses Medicare Advantage and was in a --  
15 I'll pick one -- Plan J or something now with drugs.  
16 They're going to leave J forever then. But they can't go  
17 back for except for -- do you know, Jill, is it Plan C  
18 that's always available every year? Or is it a different  
19 one?

20           DR. BERNSTEIN: With the drug plans, they can go  
21 into a plan which is -- they have a 63 day period to go into  
22 an equivalent or less -- any plan, sort of an open

1 enrollment thing.

2 DR. BERTKO: The drug plans get better. Let me  
3 make it a little simpler, because Part D will now be --

4 DR. BERNSTEIN: The other ones, yes, it's only C  
5 and maybe a couple of others, A or F.

6 DR. BERTKO: So there's a restriction on what you  
7 can get in, although maybe that's a moot issue because most  
8 people are in C and F anyway and the other plans are almost  
9 invisible, in terms of this. But it is a one-way street in  
10 some cases. You can go out of Medigap into Medicare  
11 Advantage, but you may not be able to come back from Medicare  
12 Advantage into a particular Medigap option.

13 MR. HACKBARTH: John, could we go back to your  
14 first point. You're suggesting that the federal government  
15 mandate community rating for all Medigap plans?

16 DR. BERTKO: I don't think that was our charge.  
17 I'm taking our charge here as suggesting things for the NAIC  
18 to look into. I think MedPAC's charge overall was to help  
19 seniors better understand their choices. To me, this might  
20 be one that we want to think about a little bit. I'm not  
21 even suggesting it come to the level of a recommendation,  
22 but thinking through and perhaps discussion might be

1 worthwhile.

2 DR. MILSTEIN: In some ways, I think Medicare  
3 programs should be grateful that these plans did not put the  
4 pedal to the metal in terms of doing more to reduce premium  
5 costs for Medigap. Because if you think about the band of  
6 cost that Medigap covers, if you really wanted to minimize  
7 spending in those areas, it's likely impact would be to  
8 substantially increase what Medicare would end up paying.

9 Think of it this way. Most of what Medigap covers  
10 is dominantly skewed toward drugs and physician office care,  
11 not inpatient care.

12 DR. BERTKO: I'd have to disagree with that on an  
13 actuarial basis. Medigap basically occurs after some  
14 Medicare service is provided and has, in my opinion,  
15 virtually no driving affect on the level other than the  
16 induced demand from completely filling in the cost sharing.

17 DR. MILSTEIN: That's the point I'm making, is if  
18 you wanted to -- I mean is there an opportunity here for us  
19 to engage Medigap plans in contributing to reduced spending  
20 growth with respect to Medicare Part A and Part B?

21 The idea here being most of the opportunities to  
22 better manage patient care that potentially a Medigap plan

1 could be potentially incentivized to encourage would be  
2 likely to reduce inpatient utilization. But in order to do  
3 it, you might have to invest a little bit more in physician  
4 utilization and in drug utilization.

5           If you look at this from the perspective of  
6 employers who are providing the equivalent Medicare  
7 supplemental plans, when they begin to think about should  
8 they -- they often will think should we apply the same  
9 managed-care techniques, including provider incentives, to  
10 we apply when we're primary. For example, pre-Medicare 65,  
11 they do the math and they go this makes no sense at all  
12 because if we did anything with our supplemental plans to  
13 encourage better performance, as it were, it actually would  
14 have the effect of saving the Medicare program money and  
15 costing us more money as we beef up more of the ambulatory  
16 care services.

17           So right now, reasoning analogously, people who  
18 operate Medigap plans have absolutely no incentive to try to  
19 better manage care and create better outcomes for the  
20 Medicare program.

21           So my question is, should we discuss opportunities  
22 for changing the incentives that we give Medigap plans such

1 that they begin to row in concert with the rest of the  
2 Medicare program and have incentives to begin to both reduce  
3 the rate of increase in the Medicare program overall and  
4 improve quality of care?

5 MS. BURKE: Could give me an example? I'm not  
6 sure I have a clue what you're suggesting.

7 DR. MILSTEIN: You operate a supplemental plan to  
8 Medicare, you're a secondary payer; right?

9 DR. BERTKO: Say Blue Cross of XXY.

10 DR. MILSTEIN: And somebody comes to you and says  
11 there's a highly effective program to manage congestive  
12 heart failure for this population. And we can reduce  
13 overall spending quite a bit. If you run the math on what a  
14 best in class congestive heart failure program would do for  
15 the Medigap insurer, it primarily would shift more burden,  
16 more spending into physician ambulatory visits and drug, of  
17 which the Medigap plans are paying a very high percentage.  
18 And its primary savings would accrue to the Medicare fee-  
19 for-service program because you're reducing  
20 hospitalizations.

21 MS. BURKE: I'm just trying to understand  
22 structurally what is it that you would do to the Medigap

1 insurance?

2 DR. MILSTEIN: If the objective is to change the  
3 incentives around people who operate Medigap programs such  
4 that they now feel that they're also now trying to, among  
5 other things, reduce rate of growth in Medicare per capita  
6 spending and improve quality, what you might offer is --  
7 let's call them P4P incentives for Medigap plans.

8 So that at the margin, they would potentially get  
9 a payment from Medicare if they achieved quality targets, if  
10 they intervened in ways that improve quality and reduce  
11 total spending in the Medicare program. They are a  
12 potential player, I guess, in influencing total Medicare --

13 MS. BURKE: I'm just trying to understand, given  
14 the structure of the Medigap program, given its role, the  
15 fundamental function being filling in the gaps, I'm trying  
16 to understand structurally what is it that you would do to  
17 the Medigap industry?

18 MR. HACKBARTH: What levers do they have to alter  
19 patterns of care?

20 MS. BURKE: Since they fill in cost sharing and  
21 they fill in for blood products, I mean there are very  
22 specific things they do.

1 DR. MILSTEIN: For example, they could introduce  
2 disease management programs to keep Medicare patients out of  
3 trouble and out of hospitalization.

4 MS. BURKE: So new benefits.

5 MS. RAPHAEL: Basically you have to measure them  
6 against savings in the Medicare program. That has to be  
7 your main menu.

8 DR. MILSTEIN: Yes. They're a potential  
9 additional tool if our overall objective is to reduce the  
10 rate of increase in Medicare spending and improve quality  
11 for Medicare beneficiaries.

12 MR. HACKBARTH: I agree with the objective. The  
13 question is whether this product is a fitting vehicle for  
14 trying to influence. So if we want to encourage disease  
15 management, as apparently we do, we're investing in a major  
16 pilot of that, the providers involved, the beneficiaries  
17 involved are more likely to respond to an initiative not  
18 coming from the gap filler but from the primary payer, in  
19 this case Medicare. Medicare has more leverage than the  
20 supplemental insurer.

21 DR. MILSTEIN: To the degree that Medicare is  
22 finding ways of making this happen for the Medicare fee-for-

1 service program, then the need to get help from the Medigap  
2 insurers becomes much less. I agree with the point that  
3 it's better to solve the problem through the incentives we  
4 build around the Medicare fee-for-service program. But  
5 those are sometimes not that easy to accomplish and it takes  
6 a long time. So the question is should we consider this a  
7 gap filler, as it were.

8 MS. BURKE: I don't disagree with where you want  
9 to go, it's just I'm completely missing how you use an  
10 insurance program that is essentially structurally a gap  
11 filler to drive the fundamental structure of the primary  
12 program.

13 MR. HACKBARTH: Put yourself in the position of a  
14 beneficiary. Right now Medigap is most attractive to  
15 beneficiaries who say I don't want to enroll in a private  
16 plan. I want to retain control over my own health care,  
17 free choice, and that's what traditional Medicare offers me  
18 and I love that. They're not looking to the private plan to  
19 steer them to improve their care.

20 For those beneficiaries who are looking for  
21 private plans that might be able to steer them and improve  
22 their care, we've got Medicare advantage and an increasing



1 array of different types of products that they could choose  
2 from.

3           Again, whether we want to try to invest the  
4 resources in modifying the gap filler, I guess is the  
5 question for me.

6           DR. MILSTEIN: For me the question is would a more  
7 moderate change for mainstream beneficiaries potentially  
8 attract more into what I'll call this form of plan, that is  
9 a Medigap plan that was incentivized to use a variety of  
10 tools that are available to any plan sponsor to either  
11 incentivize physicians to be more successful in longitudinal  
12 cost management and quality and/or for the plan themselves  
13 to introduce disease management.

14           Again, I completely agree with the point that if  
15 mainstream Medicare fee-for-service is accomplishing this,  
16 then there's no need for this. But to the degree it remains  
17 infinitely postponed into the future, then this is an  
18 additional tool that we might consider.

19           DR. MILLER: The only thing I was going to say is  
20 I can't bridge all the way to the point that I think where  
21 you started. If it's not clear, we are trying to look at  
22 this instrument as a way to control or to help control at

1 least expenditures by discussing and asking for advice on  
2 whether you want us to look at designing policies that  
3 eliminate the first dollar coverage and the SELECT versions  
4 of them where you choose to buy Medigap but you choose to  
5 buy into some type of network that might give you some more  
6 push.

7 I can't bridge all the way to where you were going  
8 but this notion is contemplated. The quality stuff doesn't  
9 quite -- I don't know how to make that connection.

10 DR. MILSTEIN: The way you'd make that connection  
11 is, just like any other plan, a Medigap plan could begin to  
12 introduce provider P4P based on quality, in fact using the  
13 very same measures and incentives that are being paid by the  
14 other Medicare programs, both fee-for-service and managed  
15 care.

16 The point is from a physician's point of view, the  
17 more synchronization you have across all plan types with  
18 respect to what are the quality measures and that there be  
19 some income contingent on doing well in those quality  
20 measures, the more inducement you have for physicians to  
21 move more quickly to this new vision of what health care  
22 could be that IOM keeps painting for us.

1 MR. HACKBARTH: Other questions or comments?

2 DR. REISCHAUER: To repeat something I said a few  
3 years ago, one is always struck when you talk about Medigap  
4 over the fact that 90 percent of the participants in this  
5 program have supplemental insurance coverage. It, for the  
6 most part, all covers the same stuff. Which is clearly an  
7 expression that the overwhelming majority of Americans would  
8 like a benefit package that was more rich, richer than  
9 Medicare now provides.

10 And the simple way and efficient way of providing  
11 it is to fold all of this into Medicare, into the basic  
12 benefit or to have a high level plan. And you could do it a  
13 whole lot cheaper. But instead we have this unbelievably  
14 convoluted system that then creates a whole lot of perverse  
15 incentives that then we sit around and scratch our head and  
16 say how can we fix these incentives. And Arnie comes up  
17 with his ideas and on and on.

18 Jill, the question that I wanted to raise was the  
19 finding that you have that Medigap participants spent more  
20 than any other group except Medicaid on basic Medicare  
21 benefits, which struck me as an interesting bit of analysis  
22 because in general I thought employer-sponsored insurance

1 was, on average, richer than Medigap and would induce more  
2 Medicare spending.

3 I was wondering if it was done right, in the sense  
4 in the employer-sponsored group you took out the people who  
5 have A but not B.

6 DR. BERNSTEIN: I think the big difference is that  
7 we found over the last couple of years that the cost sharing  
8 for Medicare-covered services for people with employer-  
9 sponsored coverage has increased a lot. These guys pay when  
10 they go to the hospital, and they pay when they go to the  
11 doctor, until they reach their deductible.

12 DR. REISCHAUER: I was willing to go along with  
13 that until I saw it was 2001 data.

14 DR. BERNSTEIN: We did it for 2002 and it was the  
15 same.

16 DR. REISCHAUER: I'm saying if it were 2004 data,  
17 I'd be more sympathetic. I don't doubt you, but if you took  
18 out the people who were A and not B, then I have no other  
19 explanation.

20 DR. BERNSTEIN: It's MCBS and so they're not going  
21 to make any difference because there's so few of them. I  
22 don't know if we took them out or not. but there's very few

1 of them in that set, in MCBS. I mean, it's not a whole lot  
2 -- most of them have both.

3 MR. HACKBARTH: Bob, your point is that the  
4 Medicare spending is higher for the Medigap people, as  
5 opposed to the retirees?

6 DR. REISCHAUER: And those who have employer-  
7 sponsored coverage.

8 MR. HACKBARTH: It could be a selection  
9 difference.

10 DR. BERTKO: But it's MCBS, so did you adjust it  
11 for age/sex?

12 MR. HACKBARTH: You tell me, John. I always used  
13 to hear from the HCFA actuaries that age/sex really doesn't  
14 do it here, that people who work to retirement and qualify  
15 for retiree benefits are healthier than those who do not  
16 work to retirement and qualify.

17 DR. BERTKO: But there's a different component  
18 here. The Age/sex slope of the total A/B benefit is fairly  
19 steep until you hit about 82 or 85 and then it flattens  
20 almost completely, or even turns down.

21 So you could indirectly have an older group of one  
22 or the other which might affect the total average PMPM

1 comparisons, which is what I'm assuming Jill and others are  
2 reporting on.

3 DR. MILLER: We'll follow up to answer this  
4 question, but the three components of the question are what  
5 are the basic expenditures, what's being spent out-of-  
6 pocket, and how premiums are treated in this calculation.

7 And then I think we get to this calculation of how  
8 did you adjust it? We'll come back and explain the pieces  
9 to this.

10 DR. BERNSTEIN: We have it, but we can come back  
11 and explain it next time. It's here.

12 MR. HACKBARTH: Any others? Okay, thank you.

13 Next is the mandated study on drug handling costs.

14 DR. WORZALA: Good afternoon. Last month we  
15 introduced you to this mandated study that we were given in  
16 the MMA, which is to look at whether or not we need a  
17 payment adjustment for the handling costs incurred by  
18 hospitals when they deliver certain radiopharmaceuticals,  
19 drugs and biologicals in their outpatient department. This  
20 study will be part of our June report.

21 We're going to present a little bit of analysis  
22 today to help you to deliberate the policy questions in the

1 study. I'm going to start off and then turn over to Rachel.  
2 And Sarah Kwon also worked with us on this study.

3 So what is the policy question? The MMA changed  
4 the way hospitals will be paid for these products,  
5 radiopharmaceuticals, drugs and biologicals that were on the  
6 pass-through list in December 2002.

7 Beginning in 2006, the MMA requires CMS to base  
8 payments for these products on hospital acquisition costs.  
9 GAO has been asked to estimate those acquisition cost by  
10 surveying hospitals, and we've been asked to determine  
11 whether or not there should be a payment adjustment to cover  
12 the handling costs involved in storing, preparing and  
13 disposing of these same products. And if so, how should it  
14 work.

15 Previously payment for handling costs was included  
16 in payment for the product itself. Arguably then these  
17 costs have been incorporated into the outpatient payment  
18 pool and no new money is required. However, when Medicare  
19 moves to paying acquisition costs, the payment for the  
20 product will no longer include the handling costs. How then  
21 should the payment system treat them?

22 This is a slide you saw last month, which is just

1 a reminder of the kinds of products we're talking about.  
2 Many but not all of the drugs and biologicals are used in  
3 cancer treatment. The radiopharmaceuticals include many  
4 products that are for diagnostic nuclear imaging procedures.  
5 Some are also used in treatment. FDG is used in PET  
6 scanning.

7           Our study is about the handling costs that  
8 hospital pharmacies and nuclear medicine departments incur  
9 when they store, prepare and dispose of these products.  
10 This can include things like complying with safety  
11 requirements and also quality improvement activities, as  
12 well as the actual preparation of the product itself.

13           The components of cost we're talking about are  
14 labor, equipment, supplies and disposal fees. The study is  
15 not about acquisition costs of the products or the costs  
16 associated with actually administering a product to a  
17 patient. So for example, we're looking at the cost of  
18 preparing a chemotherapy infusion in the pharmacy but we're  
19 not looking at the costs incurred in the infusion suite to  
20 administer the IV to the patient or to monitor for  
21 complications.

22           So our first question is whether or not a payment



1 adjustment is needed. It really is difficult to answer this  
2 question due to the lack of systematic data on the costs.  
3 However, there are a number of factors that suggest one  
4 might be needed. We know that historically handling costs  
5 have been built into hospitals charges and payments for  
6 drugs. In talking with stakeholders and through a survey on  
7 charge setting practices that we conducted last year, we  
8 found that most hospitals do not currently have separate  
9 charges to cover their handling costs. Rather they tend to  
10 mark up the cost of the drug itself sufficient to cover the  
11 handling costs, as well.

12           Similarly, when payment rates for these products  
13 were based on AWP, payment exceeded the costs, providing a  
14 cushion to cover the handling costs. But if payments  
15 dropped to the level of acquisition costs, the payment for  
16 the product will no longer be sufficient to cover the  
17 handling costs as well.

18           Of course, that doesn't mean that absent a payment  
19 adjustment the handling costs have disappeared from the  
20 payment pool. They would simply be distributed across  
21 payments for all services. And this point of budget neutral  
22 recalibration of payment rates is something we'll come back

1 to on the next slide.

2           Our conversations with stakeholders indicated that  
3 these costs are not negligible. Many of the products have  
4 specific storage and preparation requirements. Hospitals  
5 also have significant safety and regulatory requirements  
6 that increase their costs. For example, radioactive  
7 materials are highly regulated and require significant  
8 safety precautions with lead-lined containers and metering  
9 of staff for exposure for radiation, et cetera. Toxic  
10 drugs, including chemotherapy, require specific steps to  
11 protect both the staff and the patients.

12           We also looked at data from the state of Maryland,  
13 where hospitals submit detailed cost reports. We looked at  
14 three major components of direct costs, labor with benefits,  
15 supplies, and the actual acquisition cost of the drug. The  
16 data from Maryland told us that the drug acquisition costs  
17 accounted for 72 to 74 percent of the sum of those three  
18 components, while labor and supplies accounted for the other  
19 26 to 28 percent. So again the costs aren't negligible.

20           Finally, if the outpatient PPS did not have a  
21 payment adjustment for handling costs there could be some  
22 distributional effects. Hospitals that provide a lot of

1 these products, such as those that specialize in cancer  
2 care, would be more affected than those who don't provide  
3 them as often.

4           So while you may decide that a payment adjustment  
5 is needed, the structure of the payment system suggests that  
6 it should be budget neutral. Our study has focused on  
7 relative payments among services. What we're asking is does  
8 the payment system need additional APCs to cover handling  
9 costs? What should the relative weights for those APCs be?  
10 We're not really thinking about the level of payments or how  
11 big the payment pool is. That's really a question we  
12 address in our update discussions.

13           Also, as I alluded to on the previous slide,  
14 moving to payments for drugs and radiopharmaceuticals based  
15 on acquisition costs changes the rates for those specific  
16 products but it isn't removing the handling costs from the  
17 payment pool. When CMS changes the relative weights for  
18 services, they do it in a matter that doesn't change the  
19 total payment, just the relative weight for the specific  
20 service.

21           There are a number of factors that suggest that  
22 these costs have, in fact, been built into the payment pool.

1 First, when the outpatient PPS was first set up, the payment  
2 pool was built on charges reduced to costs. And we have  
3 been told the hospital charges for the products include a  
4 markup to cover the handling costs.

5 Second, when CMS instituted the pass-through  
6 mechanisms, which is one of the main ways to identify the  
7 products that this study refers to, it was meant to be  
8 budget neutral. That speaks to Congressional intent.

9 Third, the MMA did provide for interim payments  
10 for these products that are based on AWP, and that did  
11 increase the payment pool with a certain amount of money  
12 that won't be taken out.

13 So that was thinking about whether a payment  
14 adjustment is needed. Now thinking about what a payment  
15 adjustment might look like, one approach could be to simply  
16 markup acquisition costs. This is advantageous because it's  
17 easy to administer. However, it probably wouldn't be  
18 accurate. That's because there is really is no reason to  
19 believe that handling costs vary with the price of a  
20 product. The price of the drugs and radiopharmaceuticals  
21 depend mostly on the manufacturer's cost of production, the  
22 extent to which there are competing products within a given

1 therapeutic class, and other market factors. It really  
2 doesn't have much to do with the handling costs.

3           The handling costs really depend on what the  
4 pharmacist or the nuclear pharmacist is doing to prepare and  
5 dispose of the product. So a newer, costly drug can have  
6 the same handling costs as an older, cheaper drug. Or it  
7 may, in fact, be less expensive. Many of the newer products  
8 are produced in a format that lowers handling products. For  
9 example, they are more likely to be produced in a liquid  
10 form rather than a powder form that requires a certain  
11 amount of time and effort to be reconstituted.

12           Marking up acquisition costs is likely to overpay  
13 for the handling of expensive products while underpaying for  
14 the handling of cheaper products.

15           Another approach would be to establish a handling  
16 fee tied to the preparation or administration of a drug or  
17 radiopharmaceutical by linking it to the work done by the  
18 pharmacy or nuclear medicine department. A handling fee  
19 would be more accurate than marking up acquisition costs.  
20 It could also vary with the level of handling costs incurred  
21 for certain types of drugs. As Rachel will go into later,  
22 different kinds of drugs do, in fact, result in very

1 different levels of handling costs.

2           This approach would have some administrative  
3 burdens. CMS would need to establish codes and payment  
4 rates and hospitals would have to bill new codes and set  
5 charges for them. While adding some burden, this approach  
6 would at least give us a source of information on these  
7 costs by collecting hospital charge data.

8           A third option would be to move away from paying  
9 for drugs separately and developing broader payment bundles  
10 that include the drugs and radiopharmaceuticals with related  
11 services. This option is certainly more in line with the  
12 original conception of the outpatient PPS. It would,  
13 however, require legislative action.

14           Now I'm going to turn things over to Rachel.

15           MS. SCHMIDT: With a contractor's assistance, we  
16 formed a panel of experts to help us devise a framework to  
17 define what these costs are in specific terms that would be  
18 understandable to hospital officials and interpreted  
19 consistently across facilities.

20           That panel consisted of seven experts in pharmacy,  
21 nuclear medicine, hospital finance and cost accounting. The  
22 framework they devised consists of four functions of

1 pharmacy and nuclear medicine departments that are shown as  
2 the four long boxes on this slide, as well as department-  
3 wide functions shown as the wide box along the top.

4           The wide box represents pharmacy and nuclear  
5 medicine management and includes typical management  
6 activities such as record-keeping, personnel and training as  
7 well as safety, quality control and regulatory compliance  
8 activities.

9           For example, accredited hospitals much follow U.S.  
10 Pharmacopeia guidelines for sterile compounding, as well as  
11 National Institute for Occupational Safety and Health rules  
12 for protecting workers who come in contact with anti-  
13 neoplastics.

14           As you can imagine, the preparation and handling  
15 of radiopharmaceuticals are subject to very specific state  
16 and federal safety standards. Storage refers to maintaining  
17 drug and drug components in appropriate conditions so that  
18 the products don't lose their therapeutic value. For  
19 example, some products need to be kept refrigerated at  
20 certain temperatures. This category also includes inventory  
21 management.

22           Preparation refers to mixing, compounding or

1 reconstituting a drug for administration to the patient.  
2 Sometimes these activities require special equipment, such  
3 as laminar flow hoods, to ensure proper ventilation. This  
4 function also includes the time pharmacy and nuclear  
5 medicine personnel spend reviewing orders and calculating  
6 and verifying proper dosages for patients.

7           Transport refers to delivering drug to the  
8 location where it will be administered to the patient, while  
9 disposal means getting rid of the drug, waste and supplies  
10 within the pharmacy department itself.

11           We designed the framework so that all types of  
12 handling costs covered by this study fit within these  
13 categories. The components of costs are labor and benefits  
14 for pharmacists, nuclear pharmacists and technicians, the  
15 hospital space they occupy, equipment and supplies and  
16 support contracts. Obviously a pharmacist may spend more of  
17 his or her time on some functions rather than others, for  
18 example on departmental management and preparation while  
19 contracting out for waste disposal.

20           Pharmacy and nuclear medicine handling costs vary  
21 considerably across the more than 230 products we identified  
22 as special covered outpatient drugs. For example, they



1 include simple oral solid pills as well as drugs that must  
2 be reconstituted slowly and prepared for IV infusion.  
3 Radiopharmaceuticals add an even greater level of complexity  
4 where nuclear medicine departments must monitor the half-  
5 life of the products and keep patients to a tight schedule  
6 in order to ensure that they get the proper dosage.

7 Our expert panel came up with categories of the  
8 products that are grouped by combinations of the  
9 characteristics shown on this slide.

10 Clearly, the expert panel suggests dividing  
11 products into nine categories, which are shown in the table  
12 that's in your mailing materials, but that number could  
13 change once we finish collecting information from case study  
14 hospitals. The strategy behind developing these categories  
15 was to group products that have similar handling costs.

16 The expert panel concluded that radioactive  
17 products are the most costly to prepare and store because of  
18 all of the safety and regulatory requirements involved with  
19 handling them.

20 Toxic products tend to have higher handling costs  
21 than non-toxic ones because of the special equipment and  
22 processes one must follow to protect pharmacy workers and to

1 ensure patient safety. The route of administration of a  
2 product matters because our expert panel told us that the  
3 preparation and handling of IV products generally require  
4 more resources than preparing simple injections or pills.

5           We're using a case study approach to validate our  
6 framework and to get a sense of how handling costs differ  
7 across the nine categories of products we just talked about.  
8 We considered surveying hospitals but soon realized that  
9 with the variety of accounting practices used in hospitals  
10 and differences in definitions of what these costs are, we  
11 couldn't ensure that survey responses would be comparable to  
12 one another.

13           So instead, our contractor got the assistance of  
14 pharmacy and finance directors at four facilities, two large  
15 urban and two other urban, to help us with this exercise.  
16 Three are hospitals or hospital systems and one is a  
17 outpatient cancer center at a major teaching hospital.

18           Those facilities are taking on two tasks. The  
19 first task is to categorize as many of the 230 or so  
20 products as they dispense into the nine categories that our  
21 expert panel devised. The second task involves undertaking  
22 a microcosting of one product, that is the same product, for

1 each category. Pharmacists and nuclear pharmacists on our  
2 expert panel selected a typical product from each of the  
3 nine categories to cost out. The first task was completed  
4 by all four facilities and a fifth hospital agreed to do  
5 this task but not the microcosting.

6 Preliminary results suggest that the categories  
7 are holding up well. With some minor modifications,  
8 hospital pharmacists placed the products into the same  
9 categories about 89 percent of the time. When there was a  
10 disagreement about where to categorize a product, it usually  
11 had to do with differences across facilities in how they  
12 purchased the product. For example, one hospital might  
13 purchase a drug in solution form while another might  
14 reconstitute it from a powder.

15 The second task is still underway. We will not  
16 learn about the absolute levels of handling costs, just the  
17 relative relationships among categories. This is partly to  
18 ensure confidentiality of each of the facilities' cost data  
19 but also because we know we cannot determine absolute costs  
20 from four case studies and then generalize from those  
21 results.

22 Note that none of our case study facilities

1 compounds their own radiopharmaceuticals. Most hospitals  
2 rely on commercial specialty radiopharmacies to deliver unit  
3 doses. For that reason, we think that the issue of how to  
4 pay for handling costs of radiopharmaceuticals deserves  
5 further study by CMS.

6 DR. WORZALA: Since this is March, we felt obliged  
7 to come up with our draft recommendations and this is our  
8 first draft recommendation. CMS should establish separate  
9 budget neutral payments to cover the costs hospitals incur  
10 for handling drugs and radiopharmaceuticals paid based on  
11 acquisition costs under the outpatient PPS.

12 What I read is a little bit different than what's  
13 in front of you but it has the same gestalt. Sorry about  
14 that. I didn't realize that I had something else there.

15 This next slide looks at a different question  
16 which is if the Commission does recommend a handling fee,  
17 how would CMS collect the data to set the payment rates?  
18 For the long run, one option would be periodic surveys, the  
19 MMA requires GAO to conduct surveys of hospitals'  
20 acquisition costs for products, followed by periodic surveys  
21 by the Secretary. So you could possibly add questions on  
22 handling costs to those surveys.

1           However, our experience has been that there are no  
2 standard definitions for the handling costs and considerable  
3 variability in the hospital's accounting practices that  
4 might make it very difficult to interpret the results of  
5 such a survey.

6           Another option might be to conduct large-scale  
7 microcosting studies similar to those being done in our case  
8 study hospitals. Given the breadth of products, it would  
9 need to be costed. And the number of hospitals that you  
10 would need to have a representative sample, this could be a  
11 prohibitively expensive option for CMS.

12           A final option is to set payments for the handling  
13 fee the same way CMS sets payments for all other services,  
14 which is by reducing hospitals' charges to costs. This  
15 approach is administratively easiest. It does require the  
16 additional burden of asking hospitals to develop those  
17 charges. In addition, there may be a transition period  
18 before hospital charge data are really complete enough to be  
19 used in rate setting.

20           These options are for the long run. CMS would  
21 also need to set payment rates in the short-term, perhaps as  
22 soon as the 2006 payment year. In the short run, a small

1 number of microcosting studies could possibly be done to  
2 establish payment levels and relatives across categories of  
3 products and handling fees.

4           Alternatively, CMS could identify the current  
5 total pool of payment for these products. And since they  
6 will be basing payments on acquisition costs, they could  
7 estimate what of that current payment pool is for  
8 acquisition and assume that the remainder covers handling  
9 costs, and then use estimates of volume and relative costs  
10 across categories to set payments in the interim.

11           So those are our ways of getting information and  
12 setting payment rates.

13           Our second draft recommendation addresses how a  
14 payment adjustment should be defined, were there to be one.  
15 It has three parts. The Secretary should define a set of  
16 handling fee APCs that group drugs, biologicals and  
17 radiopharmaceuticals based on attributes of the products  
18 that affect handling costs. The Secretary should instruct  
19 hospitals to submit charges for those APCs. And the  
20 Secretary should base payment rates for the handling fee  
21 APCs on submitted charges reduced to costs.

22           Up to now, and in considering those

1 recommendations, we've accepted the premise of this study  
2 which is that drugs and radiopharmaceuticals will be paid  
3 separately and based on their acquisition costs. However,  
4 that approach to paying for drugs is a result of significant  
5 unbundling in the outpatient PPS, which may be an issue you  
6 want to talk about a little bit.

7           The outpatient PPS originally bundled payment for  
8 drugs and radiopharmaceuticals into related procedures. A  
9 series of legislative and administrative actions have led to  
10 a much more granular payment system, particularly for drugs.  
11 So at the moment, there is tremendous variation in the  
12 degree of bundling across services.

13           If you look at the ambulatory surgeries, the  
14 bundle is really quite large, encompassing all hospital  
15 staff and supplies needed in the operating room as well as  
16 during recovery. By contrast, all drugs costing more than  
17 \$50 per administration have their own APC.

18           As a result, there are a disproportionately large  
19 number of APCs for the separately paid drugs. If you look  
20 at the 2005 fee schedule, there are about 400 APCs for all  
21 of the clinic visits, procedures and diagnostic tests that  
22 make up 90 percent of the payments approximately. And about

1 300 APCs for the separately paid drugs that account for less  
2 than 10 percent of the payments.

3           So this very granular approach to paying for drugs  
4 takes away the incentives for efficient use of services that  
5 are built into a larger payment bundle. If a hospital uses  
6 additional drugs, it gets additional payments. Hospitals  
7 also have an incentive to use more expensive separately paid  
8 drugs over the few less expensive drugs that are currently  
9 packaged.

10           Having such a granular classification also makes  
11 it difficult for CMS to set payments. Given the tools  
12 available to CMS, the claims and the cost reports, it's very  
13 difficult to set payments for individual products. There is  
14 considerable likelihood that there will be variation in the  
15 payment rates from year-to-year when you get down to such a  
16 fine level.

17           So from a payment policy perspective, more  
18 bundling may be desirable. Identifying larger bundles could  
19 help overcome these problems that I just went through. It  
20 could perhaps also allow for more innovative payment  
21 approaches, such as looking at quality and efficiency. For  
22 example, a bundle might include a whole episode of



1 chemotherapy treatment rather than having a separate payment  
2 for each drug, each handling fee and each administration of  
3 a drug to a patient. And if you had a larger bundle like  
4 that, you could think about quality, you could think about  
5 efficiency, and maybe you could counteract some of the  
6 negative incentives in such a granular payment approach.

7           Of course, defining larger bundles would take a  
8 certain amount of research. This is something that MedPAC  
9 could possibly take up. And perhaps CMS could also be  
10 pursuing.

11           I'll stop here and listen to your discussion.

12           DR. REISCHAUER: Chantal, are there huge economies  
13 of scale in this kind of operation? Or does the average  
14 hospital fit in the range? Because there must be economies  
15 of scale.

16           DR. WORZALA: There are a lot of questions of  
17 scale and scope and how this differs across hospitals, since  
18 we are talking about the outpatient here. Some hospitals  
19 have one pharmacy that does inpatient and outpatient  
20 together. Other hospitals, particularly those that have a  
21 large cancer focus and have an outpatient fusion center, may  
22 have a special outpatient pharmacy.

1           So there are lots of issues of size and scope that  
2 would get into efficiencies. So I think it is difficult to  
3 tease out that without also thinking about the variation  
4 across hospitals and how many of these services they  
5 provide.

6           DR. REISCHAUER: So no matter what we do, we're  
7 going to end up with a rather approximate add-on?

8           DR. WORZALA: Yes. I think it would be very  
9 difficult to be precise in measuring these costs.

10          DR. SCHMIDT: If I could just add a little bit, I  
11 think there are some significant economies of scale,  
12 particularly when you have very specialized equipment  
13 involved. The radiopharmaceuticals come to mind where you  
14 have very specialized equipment and lots of safety  
15 regulations. So, obviously larger volume there does lead to  
16 economies of scale.

17          MR. HACKBARTH: Others?

18          DR. WOLTER: Just on my own experience, I would  
19 support trying to get to bundling larger units. I certainly  
20 hear from our staff about decisions they're facing on which  
21 drugs to choose and the financial incentives to choose one  
22 that's equivalent over another because it's a separate

1 payment. It would be nice if we could find our way through  
2 that.

3 MR. HACKBARTH: Without the benefit of Nick's  
4 firsthand experience, conceptually I've been troubled by the  
5 fact that we've been getting to smaller and smaller units.  
6 The question I would ask, though, is for help in evaluating  
7 where this fits in the grand scheme of priorities, both for  
8 MedPAC and potentially also for CMS. I'm not sure how to  
9 evaluate that.

10 DR. MILLER: Let me parse at least a couple of  
11 things. The handling cost issue was a mandated report. And  
12 in that sense, we want to just respond to the mandated  
13 report. It's due in June?

14 DR. WORZALA: It has a due date of July 1 but it  
15 will be in the June report.

16 DR. MILLER: So we want to deal with that and  
17 address and respond to the Congress.

18 The way I would think about the bundling issue is  
19 an agenda item that we've had, which has been stalled  
20 because of the MMA and some of the additional stuff that we  
21 got into, has been to look at the outpatient department  
22 prospective payment system more broadly, much like some of

1 the things we're going to talk about on post acute care  
2 later on this afternoon. We've had it in place for a couple  
3 of years.

4 Lots of things have been happening. Lots of  
5 things have been happening in particular as it relates to  
6 drugs and sort of parsing out how we pay for that. And I  
7 would see your discussion at the end of the bundling on  
8 drugs could be thought of as part of this larger effort that  
9 we're going to try and drive to as soon as we get out from  
10 under some of our other work.

11 Is that a fair comment, guys?

12 MR. MULLER: Part of my understanding that we have  
13 these add-ons and so forth is that given the whole CMS  
14 workload issue and so forth, it's just too hard to keep up  
15 updating. And therefore the argument that the new drugs and  
16 therapies weren't being introduced rapidly enough, if there  
17 were bundles -- if the APC was not appropriately updated.

18 So therefore, you disaggregate to have an  
19 incentive or at least have an acknowledgment of the cost of  
20 doing these things. So it does go back in some ways to that  
21 whole issue of how to update to allow for appropriate  
22 innovation.

1            Obviously, in the DRG system and the bigger  
2            payments, plus or minus something on drugs gets -- I  
3            wouldn't say get lost, but it's a smaller part of the  
4            overall DRG. And with all these APCs, where we have almost  
5            as many APCs as we have DRGs and climbing faster than the  
6            DRGs have, it's been harder to both update them and to  
7            capture the new product.

8            So I think that's an ongoing issue in the CMS  
9            environment. So I think they'll be a lot of pressure from  
10          the folks who like to bring new things in to say how do we  
11          get them updated in prompt enough time?

12          MR. HACKBARTH: Other thoughts on this, on either  
13          aspect? Okay, thank you.

14          Now we turn to a series of presentations related  
15          to post acute care.

16          MS. CARTER: I'll get started.

17          The Commission has long stated that Medicare's  
18          payment policies in the post acute setting should focus on  
19          the patient and not the setting. Providers should be paid  
20          according to the care needs and resource requirements of the  
21          patients, not where the care was provided.

22          To design a uniform payment system for all post

1 acute care, the same information about the clinical  
2 characteristics and resource needs of the patients across  
3 post acute settings is required.

4           Today I'm presenting our initial analysis of the  
5 patient assessment tools required by Medicare. We compared  
6 the information gathered by each of the patient assessment  
7 tools. And for the dimensions that were common, we compared  
8 the definitions of care that the time periods assessed and  
9 the scales used by the tools to see how similar these tools  
10 really are. This information will be considered in the June  
11 report chapter on post acute services. At the end of the  
12 presentation, I outline possible future research topics that  
13 we seek your guidance on.

14           Let's start by confirming why we need common  
15 information about patients seen in different post acute  
16 settings. As I mentioned, to design a payment system that  
17 spans post acute settings, we'll need the same information  
18 about clinical characteristics and the resource needs of the  
19 patients across all post acute settings.

20           Common information is also needed to monitor the  
21 amount and the timing of actual service provision as a way  
22 of evaluating how the payment system is working.

1           And last, we would like to use the information to  
2 evaluate the quality of care and patient outcomes achieved  
3 in each of the settings

4           Currently Medicare requires three of the four post  
5 acute care settings to use a specific patient assessment  
6 tool. The Minimum Data Set is required for SNFs. The OASIS  
7 is required for home health agencies. And the IRF-PAI is  
8 required for inpatient rehabilitation facilities. This  
9 instrument is based on the Functional Independence Measure  
10 that's also known as the FIM.

11           Long-term care hospitals are not required to use a  
12 patient assessment tool, though many do, using the APACHE or  
13 the FIM tools.

14           All of these tools were developed independently  
15 and for different purposes. The MDS was developed as a care  
16 planning tool. The OASIS was designed as a quality  
17 measurement tool, and to evaluate patients' ability to  
18 function in a home setting as opposed to an institutional  
19 one. The IRF-PAI is designed to evaluate and monitor  
20 patient outcomes.

21           Partly reflecting these different purposes, these  
22 tools vary considerably in how frequently they are

1 administered, the time period covered by the assessment, the  
2 time they take to complete, and the scales used to  
3 differentiate patients.

4           For example, in the MDS, it's administered early  
5 in the admission at day 14, and if the patient stays long  
6 enough at day 30 and every 30 days thereafter. The measures  
7 generally cover a seven-day look back period and record what  
8 a patient was able to do as well as the kind and the most  
9 amount of help the patient needed during those last seven  
10 days. The instrument takes about 90 minutes to complete.  
11 Patients are differentiated into three or four categories  
12 depending on the measure.

13           In contrast, the IRF-PAI is done at admission and  
14 discharge and records the patient's condition on day three  
15 and at discharge. It takes about 25 minutes to complete and  
16 differentiates patients into seven groups. The scale of the  
17 IRF-PAI is opposite the other two, with the higher number  
18 meaning total Independence, whereas in the OASIS and the MDS  
19 the higher the number the more dependent the patient is.

20           Looking across the three instruments, there are  
21 four common dimensions that are assessed. These include  
22 diagnoses, the comorbidities, the functional status, and the



1 cognitive status of the patient. But within each of these  
2 dimensions the instruments vary considerably.

3           Let's start with diagnosis and comorbidities. We  
4 see that ICD-9 codes are not consistently used by the tool.  
5 And when they are, the recording is not uniform. The OASIS  
6 requires only three digits, whereas the IRF-PAI requires  
7 five. The MDS doesn't use ICD-9 codes at all, but instead  
8 includes a check-off list.

9           The number of diagnoses and comorbidities also  
10 different. The IRF-PAI has space for 10. The OASIS has  
11 space for five.

12           The lack of uniform ICD-9 coding will limit  
13 whether the severity of patients can be assessed and  
14 compared. For example, although the OASIS does not gather  
15 complete ICD-9 codes, it asks that each diagnosis code be  
16 rated on a four point severity scale. While this  
17 information is used to assess the severity of patients  
18 within that setting, it cannot be used to compare those  
19 patients treated in other settings.

20           This lack of comparability across tools will  
21 substantially limit how their data can be integrated.

22           Evaluating functional status is key to assessing

1 post acute patients. Here are the elements that are  
2 evaluated by all of the tools. That said, the tools use  
3 different definitions of activities included in each of  
4 these elements.

5           For example, under walking and feeding, the tools  
6 differed in how they evaluated patients who used assistive  
7 devices such as walkers or tube feeding. Under  
8 transferring, the MDS excludes transferring to and from a  
9 toilet, whereas the OASIS includes this. In bed mobility,  
10 the IRF-PAI doesn't assess this measure at all.

11           In short, for many of the elements assess, what  
12 was measured differed across the various tools.

13           Even larger differences were seen in the cognitive  
14 status measures. The MDS evaluates 11 aspects of care  
15 compared with six by the OASIS and three by the IRF-PAI.  
16 Examples of these differences are on this slide. Long-term  
17 memory is not measured by each of the tools.

18           While each tool evaluates the patient's ability to  
19 make decisions, the kinds of decisions that were given as  
20 examples to correctly categorize patients varied  
21 considerably. In the MDS manual, for example, they included  
22 asking if patients know when to go to lunch and if they can

1 pick out their clothes, whereas the IRF-PAI distinguishes  
2 between ability to make complex decisions and problem  
3 solving such as being able to balance a checkbook and  
4 routine problems such as asking for a utensil when one is  
5 missing from a meal tray.

6           The tools do not systematically evaluate signs of  
7 depression.

8           Finally, the tools differ in the evaluation of  
9 behavior that may affect the amount of staff assistance  
10 required such as wandering or physically or verbally  
11 disruptive behavior. The IRF-PAI measures are so broad, for  
12 example one assesses the patient's ability to solve  
13 financial, social and personal affairs, that they may span  
14 large differences in patient characteristics.

15           In conclusion, we found that even for the  
16 dimensions of care common across the assessment tools, the  
17 activities that they encompassed and the definitions of the  
18 activities that they included varied considerably. Even for  
19 similarly defined activities, the time frames differ so they  
20 do not, in effect, capture the same information.

21           Finally, the scales differ so that a patient with  
22 the same care needs would be categorized differently by each

1 of the tools. This lack of commonality limits whether the  
2 information from the different assessment tools can be  
3 combined in a meaningful way.

4 Staff is looking for direction from the Commission  
5 about next steps to take. One option is to do further work  
6 on developing a common assessment tool. Staff could  
7 consider the data elements needed to measure differences in  
8 resource use across patients and settings, the reliability  
9 of the different measures and whether a site specific tool  
10 that fills in the gaps in information could be piloted.

11 Another option could be to consider how to  
12 restructure post acute payments. Under this option, staff  
13 could consider the design of a PPS for all post acute  
14 settings. Alternatively, staff could evaluate whether post  
15 acute payment could be bundled in with inpatient hospital  
16 payments.

17 Another option would be to consider case  
18 management approach that would overlay the current payment  
19 methods. Case managers would be paid to coordinate and  
20 manage beneficiary use of post acute services and be at risk  
21 for achieving savings and patient outcomes. Under this  
22 option, we might limit our focus to one aspect of post acute

1 care such as rehabilitation services.

2 What we're looking for from you here is for  
3 direction about which of these options you would like staff  
4 to work on.

5 I'd be happy to answer any of your questions.

6 DR. MILLER: I think this is clear to everybody,  
7 but I just want to remind you. We talked a while back and  
8 we all thought it was a good idea that we could begin -- in  
9 a perfect world you'd have a standard assessment instrument.  
10 Medicare would assign a payment and you wouldn't have all  
11 these siloed approaches to post acute care. We all thought  
12 that that was an interesting idea to pursue.

13 The subtext here is it turned out to be a lot  
14 harder than we thought it was going to be. So we're looking  
15 for some different directions to go in. And in that first  
16 bullet, we could try and pursue development of this  
17 instrument. But the thing I would want you to bear in mind  
18 is that it would probably involve either attaching something  
19 to existing instruments or developing another instrument and  
20 that has all of the burden issues that attach to it. Or we  
21 could just go off in different directions altogether.

22 MR. HACKBARTH: Let me pick up there. The problem

1 or the concern that I have is investing in developing a new  
2 common instrument or at least in the short run adding on  
3 additional burden, is a major undertaking expense to incur  
4 both for the program and for the providers. The more I  
5 learn about the underlying payment systems the more  
6 concerned I am about each of the individual payment systems  
7 for home health and SNFs and so on as you go through the  
8 post acute. So we'd be investing a lot of money in an  
9 overlay on unstable systems underneath. And that troubles  
10 me.

11 So it makes me interested in the concept of going  
12 back to the beginning and looking more at an integrated  
13 payment system that would do it right from the beginning.  
14 But then we're talking about a huge undertaking, not just  
15 for MedPAC but ultimately for CMS as well.

16 So it's a little unclear to me as to which path is  
17 the right one to go down.

18 DR. NELSON: I have a good deal of sympathy with  
19 the comments that you and Mark make because, as I read  
20 through this I was concerned and I'm having difficulty  
21 articulating exactly what my concerns are. But bear with me  
22 for a couple of minutes while I try and relate it.

1           I begin with the premise that these three kinds or  
2 four kinds of post acute care have some features in common,  
3 but they also are by and large fundamentally different  
4 services, fundamentally different products. That is the  
5 needs for a patient in a home care setting, where you have  
6 to make sure that they take their medication, that their  
7 weights are monitored and whatever is fundamentally  
8 different from a rehab unit that's supervised by physicians  
9 with intensive physical therapy. They really are different  
10 products.

11           And a nursing home, long-term skilled nursing  
12 facility, where they're working on toileting and so forth,  
13 that's different from either of those other two. And our  
14 interest, of course, is in having data so that we can make  
15 appropriate payment for necessary care of reasonable  
16 quality.

17           I see three different kinds of data that bear on  
18 this. First are the indications for entry into whichever of  
19 these settings is there. The second is to sort of define  
20 and monitor the care that is received. And the third is to  
21 make sure that there is adequate quality in that process.

22           The tools that are being used now by and large

1 address the latter two. But they really don't determine who  
2 goes into home care or long-term care.

3 MR. HACKBARTH: That was the gist of our  
4 recommendations around long-term care, for example. If  
5 people are going to go into this expensive setting, it ought  
6 to be people who clinically require these unique services as  
7 opposed to a broader group that may not require them.

8 DR. NELSON: That's the reason why for payment  
9 purposes I don't see us being able to tease out various  
10 common data elements from the existing evaluation tools  
11 because it doesn't answer that criteria for admission, which  
12 is a different bag.

13 I'm sure that there's been research done into what  
14 are the criteria but I've never really seen it nailed down  
15 very well. I can tell you that some of it is very fuzzy,  
16 has to do with the nature of home support, ancillary support  
17 from family and so forth. Some of it is just intuition.  
18 It's a hunch that the physician has about whether the  
19 patient is going to be able to make it or not at home or  
20 whether they'll really benefit from rehab or whether they  
21 need to go into a skilled nursing facility.

22 So it may be the one of the areas we would want to



1 focus on would be what is known about the indications for  
2 entry into these various settings before we got very far  
3 into defining a single PPS. In my view, the products are  
4 different enough that post acute care defies a single PPS at  
5 this point.

6 MR. HACKBARTH: Although the way I thought about  
7 it, and I may be wrong about this, is you can go down the  
8 track of saying we'll have distinct payment systems and  
9 products and define entry criteria as you describe much more  
10 clearly than they exist today.

11 Or alternatively, we can bundle it together and  
12 let clinicians close to the patient sort where the patient  
13 ought to go among the different settings and not try to  
14 write rules in the Federal Register that have clinicians  
15 decide within a framework that rewards quality and  
16 efficiency.

17 I think that's the argument for the bundling  
18 approach is to move the decision out as opposed to write it  
19 in federal rules.

20 MS. DePARLE: I'm still thinking about what Alan  
21 said, which was very thoughtful.

22 MS. RAPHAEL: Just commenting and picking up where

1 Alan left off, a couple of thoughts. I do believe the  
2 products have become more different than they used to be,  
3 because I think we're seeing a shorter stay in nursing homes  
4 and more of a rehab focus. So I think that's changed a  
5 product line in nursing homes. Rehab facilities clearly  
6 have a different product than in home health care.

7           So I think that is an important thing to think  
8 about. Because home care, in a way, is the most difficult,  
9 as we know, to define. We've been having medical students  
10 do a rotation and go on home care visits. And uniformly  
11 they have the same reaction, which is oh my god, send me  
12 back to the hospital to the bed. I didn't want to know all  
13 of this. It was so much easier in that other setting.

14           And it is very hard to sort of put the boundaries  
15 once you're in a home care setting, which is I think part of  
16 the reason it's harder to reach that definition.

17           In terms of admission, I think you have to  
18 separate out what would be clinical criteria from the  
19 process. And the process is hard to capture because first  
20 of all it's often occurring in a very short time frame. The  
21 hospital discharge planners need to get this person out. It  
22 can be in two to three hours and you have to make decisions

1 that are very definitive in a very short and often crisis  
2 oriented time frame.

3           It has to do with geographic variation and the  
4 capacity within the system at any point in time to sort of  
5 receive these people. And it has to do with patient  
6 preference because we have struggles every single week with  
7 people who want to come into home care who we don't think we  
8 can take care of safely. And they're pleading with us to  
9 come into home care.

10           And lastly, it has to do with cognitive  
11 impairments, which I think is a big determinant of where  
12 someone lands. So I think as we think about it, we have to  
13 separate these two parts.

14           I guess after I read all of this I came away with  
15 the conclusion that it was not worth investment in trying to  
16 get a universal assessment tool, that I don't think the  
17 payoff is going to be enough to try to really, in terms of  
18 what it would take. And I had thought initially that maybe  
19 through systems you could extract enough data to put it  
20 together. But when the definitions themselves are so  
21 different it really becomes very hard to do that.

22           I'm not in favor of bundling with hospitals

1 because of two reasons. One, more and more of the people we  
2 see do not come from hospitals. The trends are for more  
3 people coming from physicians, nursing homes, community  
4 referrals.

5           Secondly, I don't want to ever get to an incentive  
6 where you have to be hospitalized to get into the bundle and  
7 into the post acute care system, which I can see being a  
8 byproduct of that kind of approach.

9           So those are just some comments as I'm trying to  
10 think about where do we go from here with all of this.

11           MR. HACKBARTH: Carol, what about the case  
12 management idea? Don't give it to the hospital but have  
13 somebody whose role is to find the right place for patients  
14 in need of post acute care.

15           MS. RAPHAEL: I think these are the issues around  
16 -- I think there is value to doing that because I think  
17 having someone -- I mean anyone who tries to navigate and  
18 make decisions finds it very, very hard to do. So there is  
19 value in thinking about sort of what I call a navigator,  
20 someone who helps you find the way.

21           I think the problems are more from a pragmatic  
22 point of view. We are bringing more and more people home in

1 the evenings, Saturdays and Sundays. The pressures on the  
2 hospitals are very great. So you have to be very careful  
3 that you're not putting in layers here that really interfere  
4 with discharge of medically necessary people, which can  
5 happen and it does happen.

6           Because remember that states are trying very much  
7 to do this on the Medicaid side of the house. They're  
8 trying to divert people from going into nursing homes and  
9 moving them into home and community-based care by doing  
10 assessments and having sort of people at the gate care  
11 managers. And to some extent it works. To some extent it  
12 really ends up not making as much of a difference as one  
13 would think it would.

14           So I think it's worth taking a look at what we  
15 could do to sort of intervene. I like that idea the best of  
16 sort of the proposals that have been laid out in the last  
17 part of this.

18           DR. SCANLON: I agree with the principle that we  
19 really want the characteristics of the patient to be  
20 determining the appropriate setting and how we pay. I  
21 wouldn't bundle these four services together in terms of  
22 thinking about them globally and the distinctions that Alan

1 and Carol made are extremely valid.

2           Particularly the difference between institutional  
3 care and home care. We're expecting a whole different array  
4 of services from the institution. It's total care, 24 hours  
5 a day. There's patient characteristics that may determine  
6 whether that's appropriate. But even when the patient could  
7 be at home there's the issue that the institution is  
8 providing those services. And I think we need to take that  
9 into account in terms of our payment systems.

10           I'm not sure how high on a priority list I would  
11 put it, but I think looking at the three institutional types  
12 and asking ourselves are we doing the right thing in terms  
13 of classifying patients for these three institutional types  
14 or even within an institutional type.

15           I have a concern about what's happening with  
16 respect to the SNFs between those people that are served in  
17 the hospital-based versus the free-standing. I mean we,  
18 when we were looking at the differences in margins between  
19 these two sets of institutions, had a little bit of  
20 information or a little bit of data on the patients that  
21 might suggest that it was a more complex case than was the  
22 hospital, not enough to be definitive and say that we needed

1 to definitely do something about it, but suggest that that  
2 was the case.

3 So improving the assess instruments from that  
4 perspective to be able to refine payments across these three  
5 settings, I think is something that should be somewhere on a  
6 priority list. I'm not sure how high.

7 The bundling idea concerns me. Actually, Sheila's  
8 gone now. I first met Sheila in 1985 when we were talking  
9 about the bundling of post acute care into the hospital  
10 payment. And the same concerns about conflicts of interest,  
11 in terms of clinical judgments versus financial judgments,  
12 existed then. It's not necessarily a clinician that's going  
13 to be in charge of that payment bundle and I think that's  
14 one of the things that we need to worry about.

15 The case management idea, my concern would be is  
16 we don't have the institutional apparatus there today. And  
17 so it's a question of how quickly is it going to develop.  
18 If we put it out there is it going to develop in the form  
19 that we want it to develop? That would be my concern there.

20 MR. MULLER: These areas of care probably are more  
21 affected by payment policy than are other areas, hospital,  
22 doctors and so forth. When we see the enormous change in

1 home care, when the rules changed there for prospective  
2 payment. You see the entry and exit of SNFs is much more  
3 dramatic than ever happens on hospitals or doctors coming in  
4 or out of the program, which tells me that it's the payment  
5 rules more than the underlying needs of the patients that  
6 are driving what's going on in this area. So that's part  
7 one. We seem to have shaped this arena more through payment  
8 policy than we have the other areas of other providers.

9           Secondly, I agree with a number the previous  
10 comments that the institutional world is the one that we  
11 have to look at more fully, especially in light of all of  
12 the demographic trends that will hit us 10 or 15 years from  
13 now, as there'll be more and more need for institutional  
14 care. So getting the incentives right there is appropriate.

15           Third is this notion that there is an integrated  
16 system out there. I've already argued against it. There  
17 really isn't. These services that one likes to get, case  
18 management services for example, are few and far between.  
19 Oftentimes, they are located in hospitals for the simple  
20 reason that the hospitals have to get patients out and  
21 therefore invest a lot in case management because they need  
22 to free up those beds. If you try to get those services



1 elsewhere, you can't find them elsewhere. They don't sit  
2 out there as naturally as they do in that kind of  
3 institutional setting.

4           So I would also, I think, try and look for a  
5 uniform assessment in that sense. And just echoing what the  
6 rest of you said, it's probably not the right thing to focus  
7 on right now. I think making sure that the payment  
8 incentives -- for how many years now we've been arguing for  
9 some change in the SNF rules. And our findings haven't been  
10 acted upon as fully as they perhaps have in other areas.

11           So I think we have to keep making sure that what  
12 we're looking at, especially in the institutional setting,  
13 is consistent with what we're trying to reach. As opposed  
14 to -- for example, in the last few years there's a lot of  
15 incentive to do the rehab patient and to take on more rehab  
16 patients. I can't remember how much we predicted or people  
17 predicted that would happen with the change in rules, but  
18 it's been evident now for a couple of years, that a good  
19 share of the resources are directed to those patients and  
20 other patients are not getting the kind of access to the  
21 SNFs that they should.

22           So I think getting a reasonable handle on

1 especially institutional setting, whether the rules that --  
2 especially the payment rules -- are achieving the kind of  
3 programmatic purposes that we want, I think is of critical  
4 importance.

5 I also would agree with the previous statements  
6 that these are different products. And so with our other  
7 thoughts about the advantages of specialization that we've  
8 discussed around hospitals and thinking about the advantages  
9 of specialization here is a fruitful line for us to go down.

10 But most importantly, the payment rules are more  
11 dispositive here than they are in other areas. So we should  
12 be even more attuned to the programmatic consequences of  
13 payment.

14 Whereas in the other areas there are other forces,  
15 as well, technology, et cetera, that have a big effect on  
16 delivery of care. This is much more payment driven.

17 DR. MILLER: Just to say one thing about that.  
18 The next two presentations actually go inside these areas  
19 and start discussing the payment elements. So in a complete  
20 contradiction, we're both looking across and down. And I  
21 think some of your issues will be dealt with there.

22 MR. SMITH: I agree with a lot of the cautions

1 particularly that Carol and Alan suggested. But I do think  
2 we ought to keep in mind, as we think about the bundle  
3 option here, that in the post acute world people are likely  
4 and do and should consume more than one of these services.  
5 Carol, whether it's your traffic cop or a case manager,  
6 someone who with a common assessment instrument, with a good  
7 definition of a product in these very different suppliers  
8 who is managing and helping navigate the way through it,  
9 when is it appropriate to be in a SNF? When is it  
10 appropriate to leave a SNF and be in home health?

11 We have no other way to think about the  
12 architecture of getting to a sensible set of decisions in  
13 that circumstance without a bigger bundle. I accept your  
14 concern that the hospital may not be the right place to  
15 bundle. But at the moment it is the only place where that  
16 decision gets taken. I've got to get somebody out of a bed.  
17 Where do they go? Do they go to a SNF? Do they go to home  
18 health? Do they go to a rehab facility?

19 If we can't re-create that informed decision with  
20 some other instance, some other way of thinking about  
21 bundling, I wouldn't take the hospital as bundler off the  
22 table at this point. I don't think we know enough about how

1 we get an integrated pattern of post acute care where people  
2 are -- this is not a situation where you get your knee  
3 operated on and your ankle operated on. You may well, and  
4 are quite likely to, in an episode move through more than  
5 one of these post acute settings.

6 MS. RAPHAEL: Can I make a comment on that? I  
7 think, first of all, you have to understand that hospitals  
8 are not the only place because a lot of people in nursing  
9 homes, they can't show improvement. And therefore, they  
10 have to leave the nursing home because they can't meet the  
11 expectations. The same for rehab facilities. So there are  
12 decisions made at that point, as well.

13 So I think you could also think about bundling  
14 from the nursing home on to home care. I think it can get  
15 very complicated because there are multiple points of  
16 bundling.

17 MR. MULLER: I just want to make a comment that  
18 the notion of this seamless acute system, it doesn't exist.  
19 So there's a notion you have all these choices. A lot of  
20 times you just have to find a nail because you only have a  
21 hammer.

22 So basically you may have a SNF, you may have home

1 care. The dimensions of home care have shifted considerably  
2 in the last few years, given the payment -- the comments I  
3 made earlier, so I won't repeat it.

4 So this notion that you have this array of  
5 choices, even in urban areas which are supposing more  
6 oversupplied, you generally don't have these choices. So  
7 you're looking oftentimes to put a person somewhere, which  
8 may not be the best place. And you know you're not putting  
9 them in the right place, but it's better than nothing.

10 So I think that reality is out there, too, before  
11 we think that if we had the right instrument we all of a  
12 sudden would be put in the right place. If you want five  
13 places and you only have two, that kind of oftentimes  
14 directs you to the wrong place.

15 DR. MILSTEIN: Based on Alan's reasoning, I think  
16 that we might always want to see some facets of quality  
17 assessment being institution specific. That doesn't mean  
18 all of our quality measures pertaining to this population  
19 have to be institution specific, but some would always have  
20 to be, I think, for the reasons you cited.

21 With respect to payment incentives, I think the  
22 pros and cons of bundled payments are well known to

1 everybody around the table. My best recollection of the  
2 research evidence pertinent to this is that there is  
3 evidence of substantial, both regional and within region,  
4 hospital specific variation in the mix of use of post acute  
5 care services. And that's holding constant availability of  
6 different post acute care capacity, different types of post  
7 acute care capacity.

8           Based on that line of reasoning, I think I lean  
9 toward Glenn and Dave's vision of if it's a close call  
10 tilting toward a more bundled system which begins to get all  
11 of your pieces focused on the question of how do we optimize  
12 over time the best both patient outcome and total Medicare  
13 spending.

14           MR. HACKBARTH: Anybody else? Okay, why don't we  
15 move on then to the next, which is assisting the home health  
16 PPS.

17           MS. CHENG: This is my first presentation on this  
18 subject for this report cycle and I also will be  
19 contributing to this chapter in the June report on post  
20 acute care.

21           First, I'm going to briefly review the payment  
22 system that we've come to know and love over the last three

1 years. And then I'm going to touch on some evidence that  
2 suggests that perhaps this PPS is not working optimally for  
3 all patients.

4 The second thing I'm going to do is talk to you a  
5 little bit about some research strategies that we could use  
6 to look at the PPS.

7 And finally, I'm going to talk to you a little bit  
8 about options that I think are briefly sketched in your  
9 paper because we only have brief notions of them at the  
10 moment. It's difficult to develop a care plan before you've  
11 diagnosed the patient. And so, we're kind of doing two  
12 things at one time here.

13 The current payment system that we use for home  
14 health, the basic unit of payment is a 60-day episode and  
15 beneficiaries can have multiple 60-day payment episodes  
16 during a single spell of illness, so long as they remain  
17 eligible for the benefit.

18 The way we pay for home health services right now  
19 is by the episode. We have a base payment that applies to  
20 each episode, and that right now is about \$2,300. You take  
21 that base payment and then you multiply it by a case-mix  
22 weight. That is used to describe the relative expected

1 resource use needs of the patient in that case-mix. This  
2 system has 80 case-mix groups that are called HHRGs.

3 We also adjust a portion of the payment to reflect  
4 local prices.

5 The case-mix system that the home health PPS uses  
6 to put patients into these expected resource groups has  
7 three domains. They are clinical, functional and service  
8 use. The clinical is driven off things like the diagnosis,  
9 whether a patient has persistent pain, or whether they need  
10 parenteral nutrition, which is very resource intensive.

11 The functional domain is driven off of the  
12 functional limitations that a patient has when they are  
13 admitted to home health. So their ability to ambulate,  
14 their ability to dress themselves, or their ability to get  
15 to and from the toilet.

16 The third domain is service use. That's driven by  
17 whether or not that patient came from another institutional  
18 setting. Did they come from a hospital? Did they come from  
19 a rehab facility? And also is driven by their actual use of  
20 therapy up to a threshold.

21 So we take their scores in those three domains and  
22 we use their scores in those domains to place them into one



1 of 80 case-mix groups.

2 DR. NELSON: On the one point, Sharon, give me  
3 some other examples of the clinical domain apart from  
4 parenteral. Just give me some examples of other clinical --

5 MS. CHENG: You use the ICD-9s to put them into  
6 diagnostic groups. There are orthopedic diagnoses,  
7 neurological disorders. Diabetes would be a predominant  
8 diagnosis here.

9 It also includes wounds, whether the patient has a  
10 surgical wound. In fact, it differentiates did they have a  
11 surgical wound, a stasis wound, or a burn to try to capture  
12 the different resource uses based on those clinical aspects.

13 It also has persistent pain, their vision status  
14 is included in clinical. So they're trying to use a fair  
15 number of items from the OASIS to describe clinically what  
16 that patient is. But all persons with diabetes won't  
17 necessarily be in the same HHRG. There are several case-mix  
18 groups that they might fall into.

19 We have some evidence that suggests with three  
20 years of data under this system that it might not be working  
21 optimally for all patients. The first piece of evidence is  
22 that this payment system is neutral to high or low quality.

1 We have made a recommendation that payment systems ought to  
2 be sensitive to differences in quality.

3 We have seen, in the three years that this payment  
4 system has been in place, consistently over adequate margins  
5 every year has produced a double-digit margin under this  
6 system.

7 We also see that there is a large variation in  
8 inputs within the case-mix groups. This is what we've been  
9 talking about now for the past couple of meetings. One of  
10 the things I used to describe the differences in inputs was  
11 the variation of minutes of service within these case-mix  
12 groups. And we use the coefficient of variation to describe  
13 the very wide differences in experience that patients have  
14 within the same case-mix groups.

15 We also looked at some other information that we  
16 get from the OASIS so that we can describe patients and we  
17 can look at their characteristics in ways that are not used  
18 to adjust payments but that we observed seem to be  
19 correlated with very high costs. We found that obesity,  
20 smoking, an inability to self-administered needed  
21 medications were related to high costs. But none of those  
22 things are used to adjust payments in this system.

1           So all of these things are suggestions. They are  
2 preliminary evidence that have piqued our interests and have  
3 led us to want to look closer at this payment system.

4           What's one of the reasons that we might see that  
5 this payment system isn't working optimally? To be fair, it  
6 was developed using 1997-1998 data. In 1997 the home health  
7 product included an average of 36 visits per episode, 1,500  
8 minutes of care, and 9 percent of the visits were for  
9 therapy. In 2002, we're using the same data-driven payment  
10 system to pay for a product that has an average of 19 visits  
11 per episode. That's a decline of 47 percent. Minutes have  
12 declined 37 percent and therapy has increased 26 percent of  
13 the visits. That's an increase of 17 points. So as you can  
14 well imagine, unless all of these substantial changes have  
15 occurred precisely the same to each one of those 80 case-mix  
16 groups, then probably the way we're describing the relative  
17 needs of these patients is no longer correct.

18           Also we've seen perhaps the patients that are in  
19 these case-mix groups are not quite the same. And we've  
20 also seen the episode length decrease so that the episode  
21 that were buying might not really be describing the spell of  
22 illness and the time that patients are spending under the

1 care of the home health agency.

2 MS. BURKE: [Inaudible.]

3 MS. CHENG: I'll get back to you on that. Sheila  
4 asked whether the average age of the patient has changed and  
5 we can look at that, too.

6 So what can we do? I'd like to look at this  
7 payment system a little bit more closely. One of the things  
8 that I can do is to extend the analysis that we have  
9 discussed in the past couple of meetings of the HHRG level  
10 visits and minutes. To take it a little bit further down  
11 the road, we can differentiate these minutes. I've counted  
12 a minute as a minute. But we could see how well this  
13 payment system is doing at predicting aide minutes versus  
14 therapy minutes versus skilled nursing minutes, so we can  
15 see those differences. I can also use some other  
16 statistical techniques that I haven't tried yet and try to  
17 build some regressions and see how well this system is doing  
18 at predicting the relative minutes from group to group.

19 Alternatively, and this would be a little bit of a  
20 different direction, what we can use is a combination of the  
21 cost reports and the claims data and try to develop HHRG  
22 level costs. I could also use a regression of differing

1 statistical techniques here. The two observations I'd like  
2 to leave you with, though, is that this is very similar to  
3 research that CMS is pursuing and hopes to release soon, so  
4 our efforts might overlap there a bit.

5           The other thing would be a certain wariness that I  
6 think a lot of folks have over using this cost data. We  
7 could use a lot of statistical techniques and do a lot of  
8 massaging. But if the data just doesn't have much there  
9 there, then you've got to wonder what you come up with at  
10 the end of the day.

11           Either one of these tracks or suggestions from you  
12 could lead us to a couple of different diagnoses for this  
13 patient. What we could find is that the system as a whole  
14 isn't working so badly. Maybe all it needs is an  
15 incremental change. Maybe we just need to reweight the  
16 weights of the 80 case-mix groups and we can improve the  
17 predictive power of the system. Or we could think of other  
18 incremental changes.

19           Alternatively, we might find that this patient,  
20 rather than markers of frailty, has some fairly specific  
21 abnormalities that we'd like to treat. And that might lead  
22 us down the path of thinking of more substantial changes to

1 this payment system. So my next couple of slides are going  
2 to be possible options. As I said, it's hard to develop the  
3 care plan when you haven't diagnosed the patient yet, but  
4 these are things that staff can be thinking about and we'd  
5 like to get your reaction to these ideas.

6           The first one would be to look at a payment system  
7 that shares the risk. The idea here would be that the  
8 payment system would have a retrospective adjustment. This  
9 would be based on the agencies' costs and would be made to  
10 the agency revenues at the end of a cost reporting period.  
11 The idea here is that a risk sharing arrangement would  
12 reduce the variation in financial performance by removing  
13 excess revenue from agencies that produce more profits than  
14 they have costs. And it could redistribute payments or  
15 revenues to those that have more costs than they have  
16 revenue.

17           There have been objections to this idea from CMS  
18 and the industry. CMS has observed, from its experience  
19 under the IPS that have a system of repayments of  
20 overpayment, that overpayments are kind of tricky to get and  
21 to collect in this setting. And so they're a little bit  
22 wary of getting into that kind of system again.

1           The industry also objects to the treatment of  
2 excess revenue under a risk sharing system. The industry  
3 has contended that this excess revenue actually is very  
4 important to maintain their operations. In some cases, it  
5 is used to cover shortfalls from other payers. And those  
6 other payers might be other government payers and might be,  
7 for example, for other costs that are very similar to what  
8 Medicare pays for.

9           They also contend that this excess revenue is  
10 being used to invest in the very technologies that would  
11 enhance the quality of care.

12           One last observation is that a risk sharing system  
13 could conceivably penalize efficient providers. If low-cost  
14 providers were providing the same quality or higher quality  
15 care than their peers then they would be penalized for that  
16 efficiency.

17           Another possible option would be to imagine a  
18 payment system that had a two-part payment. One part of the  
19 payment would be a per patient payment and the other one  
20 would be per visit. The per patient would operate on a  
21 prospective basis and it could look a lot like the PPS does  
22 now.

1           The second part would be based on the actual  
2 visits by visit type that the patients received. That would  
3 be somewhat like the system that we used in 1997, although  
4 you could certainly conceive of doing it a little bit  
5 smarter in a couple of ways.

6           We could for example, rather than pay on a visit  
7 by visit type, we could use more information that we have  
8 about 15 minute increments. So we could at least narrow  
9 down the variation in visit and buy that in more reasonable  
10 increments.

11           Another idea that you could see under a cost-based  
12 per visit system would be to integrate new kinds of visits  
13 that we have seen in this setting, such as televisits or  
14 telemonitoring or new kinds of care provision that wouldn't  
15 necessarily have to be limited to a face-to-face visit.

16           This option of mixing per episode and per visit  
17 payment has a very strong incentive against stinting,  
18 although the evidence so far has been mixed on stinting  
19 despite the recent changes that we've seen in this project.

20           Your mailing materials looked at several different  
21 studies and those studies seemed to find little or no impact  
22 and very large decreases in the number of visits and minutes



1 that have followed the IPS. In our own analysis that we  
2 looked at over the past year or so, though we've seen visits  
3 continue to decline under the PPS, we have seen that our  
4 markers of outcomes have actually increased slightly.

5 A final possible option to consider here would be  
6 splitting the benefit. This would be something that we  
7 could consider if, after looking at the groups that are  
8 using home health, we found that there are one or two  
9 subgroups who have substantially consistently different  
10 needs and their use of the benefit is consistently different  
11 than the norm or than perhaps the larger group. If we found  
12 this pattern, you could imagine changing the bundle of  
13 services so that we could better meet the needs of these  
14 patients whose needs are substantially different from the  
15 norm. Or we could even contemplate developing a parallel  
16 benefit. It might be similar to a benefit that's being  
17 demoed by CMS right now, the Chronic Care Improvement  
18 Program that would be administered by home health agencies  
19 but would look quite substantially different from the way  
20 that we buy home health services now.

21 Such subgroups that you could imagine finding  
22 would be post-hospital users differing from community

1 referred users, those with no informal caregiver, those who  
2 are dually eligible or those who have markers of frailty.  
3 We might see that those groups differ in their use of  
4 services.

5           The paper sketches these resource designs, not a  
6 whole lot more meat on the bones, and to explore the various  
7 options. Staff can develop one or several of these if you  
8 wish to have more information or you want to explore them  
9 further.

10           MR. HACKBARTH: Questions? Comments? Solutions?

11           DR. WOLTER: My comments are a little bit focused  
12 on some of what I'm hearing out of the rural areas with home  
13 health. In Montana in the last three or four years, we've  
14 had about 15 agencies close. That's 28 percent of the  
15 health agencies. Three-quarters of them are hospital-based  
16 and really quite rural. And if I'm remembering right,  
17 hospital-based margins were not included in the data set  
18 that we've looked at for health margins. So that's one of  
19 the concerns they pass along to me is does that somehow or  
20 not accurately reflect some of the challenges they face.

21           And then to the point that you guys have been  
22 making, they're seeing a lot of COPD, congestive heart

1 failure, for example. The risk acuity systems don't  
2 necessarily plug in for those conditions, which they feel  
3 they uniformly lose money on when they accept those  
4 patients. So they're saying more discrimination almost  
5 against certain clinical conditions and, in some cases,  
6 mileage restrictions in terms of how far out they will go.

7           So I think we do have some work to do. And I know  
8 in the rural areas there's a lot of concern about trying to  
9 have the acuity systems better reflect what they're  
10 challenging or what they're facing.

11           The last thing I'm hearing from them is nationally  
12 there's an increase in readmissions to hospitals out of home  
13 health. And Carol, I don't know if that is what you would  
14 see or corroborate. Is that also maybe a symptom of somehow  
15 the system isn't quite recognizing what some of these  
16 patients are presenting to the home health agencies? And  
17 can we better recognize that, both in the assessment and  
18 acuity systems, but maybe in the payment system as well?

19           MS. RAPHAEL: Just a few comments. I do think we  
20 have to be mindful that there is a high readmission rate. I  
21 think it's high. It's in the range of about one-third of  
22 patients do get readmitted to hospitals. But I'm sure it

1 varies, so I think that is something to be concerned about.

2           Just two comments. One is I think we've worked  
3 very hard in home health care to get away from the sort of  
4 per visit mentality and what I consider a transaction-based  
5 system, which is what is it that you do? You make a visit?  
6 No, what you do is try to manage a case to get a good  
7 outcome. And we've worked very hard to change that. So for  
8 me, going back to sort of per visit payments does bring us  
9 back to yesteryear. So that's a concern that I have.

10           I'm sort of most interested in looking at  
11 subgroups because I think there are subgroups that use a lot  
12 of resources but don't necessarily score high in the current  
13 system that we've created. I've said this before, we find  
14 that the duals are just in a separate category. And for  
15 whatever reason, whether they crossover with the categories  
16 Nick just pointed out, but they seem to really be very, very  
17 resource intensive. So that's an approach that I would like  
18 to see us pursue.

19           DR. SCANLON: I have a concern. The double-digit  
20 margins are one issue. I think the thing that bothers me  
21 more, though, is the range of the margins, the fact that  
22 it's so wide and you've got people that are more than twice

1 the average.

2           When I look at the system conceptually, there's an  
3 opportunity there for abuse. In the sense that we haven't  
4 defined exactly what the service is. We don't really have a  
5 strong sense of the outcomes, especially for the outcomes  
6 for the longer-term patient. We certainly don't have any  
7 accountability at the individual agency levels for outcomes.

8           So the idea of getting a patient and then not  
9 providing enough services is a possibility. And when I look  
10 at this range of margins, I say to myself that's not all  
11 efficiency. Some of that is stinting. And I'm concerned  
12 about that.

13           From a Medicare prospective, if I want to spend  
14 this amount of money, I would rather redistribute it to make  
15 sure that I'm getting care for the people that need it. The  
16 system is not set up that way.

17           GAO was behind the risk sharing and I had a small  
18 part in that. I would say that some of the objections to it  
19 are overstated. CMS had problems with the IPS, in part  
20 because the IPS was such a dramatic disruption. You went  
21 from a world where we had this incredible growth over a  
22 three-year period and we suddenly capped people at the

1 national average of three years before, creating  
2 retroactively very big paybacks that had to be made.  
3 Whereas under the prior system, the retrospective cost  
4 reimbursement system, we had paybacks going on for 20 years.  
5 When an agency was overpaid one year, then it would come out  
6 of next year's payments.

7           The IPS was just such a dramatic shock that it was  
8 hard to administer.

9           Again, this idea that we're going to discourage  
10 efficiency. We're not necessarily going to discourage  
11 efficiencies through risk sharing. What we're going to do  
12 is we're going to discourage excessive reward for stinting,  
13 I think is what we can do. That's probably the primary  
14 thing that I'm concerned about about the system.

15           We saw the data, I think either last time or the  
16 time before, about growth -- and this goes counter to what  
17 Nick said -- growth in terms of the number of agencies. I  
18 worry that we will see some of the same kind of abuse of  
19 developing over time that we saw under the old system  
20 because conceptually again there's no safeguard against that  
21 within the system.

22           MS. RAPHAEL: Can I just make one comment? I just

1 think we should not only look at the number of visits, which  
2 are now 19 and were whatever before. I think the key to  
3 this system is who you admit. That's why you have the  
4 variation that you have. That's really the key point. We  
5 admit everyone. Therefore my total margin is barely 1  
6 percent.

7           If I wanted to do very well, I would be very  
8 careful about who I admit. That's a much more important  
9 variable than the number of visits that I give. And I don't  
10 know how you capture that because we're very focused only on  
11 the number of visits.

12           MR. HACKBARTH: So what I hear you saying, Carol,  
13 is that you actually may not even have to stint in order to  
14 make a substantial profit if you properly select.

15           MS. RAPHAEL: Right.

16           DR. REISCHAUER: Then what you're saying is that  
17 the payment variation is all screwed up.

18           MR. MULLER: I would say, in terms of the  
19 reweighting along the lines that we've done in specialty  
20 hospitals, this area is ripe for that, too, because we  
21 didn't just go to PPS but we went to rewarding certain kinds  
22 of patients.

1           I agree with what Nick and Carol said. We had the  
2 same experience in our area, that the medically complex  
3 patients, you can't get other people to take them because  
4 the payment system doesn't pay medically. The rehab  
5 patients you can make a lot. So it's very parallel to our -  
6 - without extending the specialty hospital discussion too  
7 much, some of the same themes that play out there play out  
8 here. So a reweighting, as we recommended there, could be  
9 something. That's one of the things that we have in here  
10 that I think makes sense to look at.

11           MR. HACKBARTH: It wouldn't just be a matter of  
12 reweighting in this case. It would be subdividing and more  
13 precisely redefining the groups and then properly  
14 calibrating the weights for the different categories.

15           MS. CHENG: Just as a note, we do have a mandated  
16 study that we will be pursuing over the summer that looks at  
17 the relationship of case-mix and financial performance. And  
18 so we will this summer, with the help of a contractor, be  
19 looking at agencies with different margins and trying to see  
20 whether we can measure and identify different patients that  
21 are going into different agencies.

22           MR. HACKBARTH: Although Sharon, when we do that,



1 if the case-mix descriptions are too broad it confounds the  
2 results because you'll start to have people with identical  
3 case-mix as measured by the system with dramatically  
4 different profit margins because the game is subdividing  
5 within the case-mix.

6 MS. CHENG: And I don't think we'll get to all of  
7 that but we have asked the contractor to use some data that  
8 we have from CMS that has the entire OASIS, not just the  
9 ones that are used for payment, not just the payment items,  
10 but all of the items on that.

11 So in addition to looking for the patient  
12 characteristics that go into the case-mix, we'll be able to  
13 look at obese patients or smokers or dually eligible. So we  
14 might be able to get at some patient characteristics that  
15 are causing those differences but aren't in the case-mix.

16 MS. BURKE: I just had a question that I wanted  
17 ask Carol and follow up on a comment that Carol made which I  
18 instinctively believe is correct, which is the radical  
19 difference, in this case, between dual eligibles as they  
20 present and the resource needs for a dual eligible on  
21 average as compared to non-dual eligible patient and a more  
22 traditional patient, and whether what we can learn from that

1 and how you might imagine going forward one might adjust for  
2 that.

3           Because arguably you see it on acute care side, as  
4 well, where they present a much more complicated, much more  
5 dependent situation because of comorbidity. A lot of  
6 things, some of which you can measure and some of which you  
7 can't. Just following on that, I guess the question is  
8 Carol, how might you imagine as we look at this question,  
9 and to the extent that we're going to pick up some of that  
10 potentially this summer, whether that plays out in terms of  
11 what these margins look like.

12           But the question is how you would adjust for that?  
13 Because it is a particular class of patient, but almost  
14 routinely, it seems to me, present a different set of  
15 problems that end up being very resource intensive.

16           MS. RAPHAEL: I don't know enough about the  
17 characteristics, but I think for example there's a greater  
18 prevalence of cognitive impairment in the dually eligible  
19 population. I don't know how we're creating the case-mix  
20 now adequately accounts or what it means when you have a  
21 cognitively impaired patient who has a complex medication  
22 regime and how you have to help that person manage that

1 medication regime. So those are some of the things that I  
2 think we do need to take a look at.

3 I know the whole issue of informal caregivers is a  
4 difficult issue. And I think there is greater absence of  
5 informal caregivers in our poorer population than in some  
6 instances. I know that CMS has been reluctant to try to  
7 reward the absence of informal caregivers because they're  
8 afraid they'll encourage the absence of informal caregivers.

9 I think you're right, I don't know how we  
10 translate what we find out into changing the payment system.  
11 I do believe there is more CHF, more COPD, some of the more  
12 chronic conditions among that population.

13 MS. BURKE: It's not surprising, if you think of  
14 the presence of obesity, the use of smoking, where there are  
15 characteristics in a lower income population that may be  
16 more prevalent, dietary habits. All of that can contribute  
17 to presenting conditions that complicate things.

18 MR. MULLER: One place to look, and I'll ask  
19 Sharon or Carol or whoever, you may want to look. Do the  
20 Medicaid rules vary at all, the payment rules, compared to  
21 the Medicare? Because obviously a lot of these kind of  
22 social issues that go through the Medicaid population from

1 age one to 65, when they become duals. You just don't call  
2 them duals when they're under 65, they're only on Medicaid  
3 obviously. But a lot of these are very much -- whether one  
4 is dealing with child welfare or dealing with young adults,  
5 as well.

6 MS. BURKE: Is your question does Medicaid --

7 MR. MULLER: Do some Medicaid systems have some  
8 better adjustments of that then perhaps we have here at  
9 Medicare because they deal with those issues all the time.

10 MS. BURKE: They pay less.

11 MR. MULLER: They pay less but they may have a  
12 more sophisticated system on which they pay less.

13 DR. REISCHAUER: While we're peppering you,  
14 Sharon, are disproportionate numbers of duals disabled?

15 MS. RAPHAEL: That's a very important question.  
16 And also, you may find that the younger disabled population  
17 could be a big factor.

18 MS. BURKE: It could if they're SSI, if the  
19 contributing factor is whether they're SSI recipients,  
20 unlike the OASDI, which would be not necessarily duals.

21 DR. SCANLON: To answer Bob's question, in part  
22 they are because one of the routes to becoming a dual is the

1 fact that you had large medical expenses and you became  
2 medically needy and that made you Medicaid eligible.

3 But going back to Ralph's, most Medicaid agencies  
4 don't use home health. They rely on the home and community-  
5 based services. They may use assessment instruments. They  
6 may use them in a very qualitative way. We did a study  
7 which looked at prescriptions of services to individuals.  
8 We created prototype individuals and asked caseworkers what  
9 would these people get. And caseworkers sitting in the same  
10 office prescribed completely different packages of services  
11 for them and then they would then be paid for on an  
12 individual fee-for-service basis. But the volume is  
13 controlled by the caseworker.

14 It's all over the map and there's nothing like the  
15 Medicare system that I know of in any state Medicaid  
16 program.

17 MR. HACKBARTH: Any others? Okay, let's then move  
18 to the SNF PPS.

19 MS. LINEHAN: In the BIPA, the Congress directed  
20 HHS to study different systems for categorizing patients to  
21 account for resource use differences across different  
22 patient types in skilled nursing facilities. CMS awarded a

1 contract to researchers at the Urban Institute to fulfill  
2 this mandate and a report to Congress was due January 1,  
3 2005 but CMS has not yet provided their report.

4 CMS has not indicated what, if any, action they  
5 may take this year as a result of this work. And when and  
6 if the payment system is refined, according to current law  
7 several temporary payment add-ons will expire.

8 The President's budget, as Rachel talked about  
9 this morning, shows savings of \$1.5 billion from the  
10 expiration of these add-ons in 2006 but doesn't provide any  
11 detail about refinement.

12 So as we wait the release of these findings of the  
13 Urban study and contemplate the implications, I'll review  
14 problems with the current SNF payment system and past  
15 research on proposed payment system revisions in preparation  
16 for future conversations about revising the SNF PPS.

17 Now that I've given some context, I will review  
18 the current payment system, some of the criticisms of that  
19 system and then I'll discussed so options for revising  
20 Medicare's SNF payment policy that have previously been  
21 considered and may provide foundation for future directions.

22 As you know, Medicare's per day base payment rates

1 to the SNF are adjusted for case-mix using the RUG-III  
2 classification system. There are currently 44 categories in  
3 the RUG-III system, as depicted on the slide. Assignment to  
4 a RUG-III category is based on several items, the number of  
5 minutes for therapy used or expected to be used, the need  
6 for certain services such as respiratory therapy or  
7 specialized feeding, the presence of certain conditions such  
8 as pneumonia or dehydration, an index based on the patient's  
9 ability to independently perform four ADLs, and in some  
10 cases signs of depression.

11 Beneficiaries may qualify for more than one  
12 category but are assigned to the highest payment category  
13 for which they qualify. SNF patients assignment to a RUG-  
14 III is determined by assessments using the MDS. As Carol  
15 said, SNF patients are assessed using the MDS at the 5th,  
16 14th, 30th and every 30 days thereafter in their stay.

17 Here are two examples of RUG-III categories and  
18 their associated indexes. The first is for a rehab RUG and  
19 the second is for an extensive services RUG. As you, each  
20 RUG-III category has associated nursing and therapy indexes  
21 to adjust the nursing and therapy base rates for relative  
22 resource use.

1           Here's a simplified example of determining the  
2 total case-mix adjusted rate. Each base rate is multiplied  
3 by its respective index associated with a given RUG-III and  
4 then these components are added together. All RUG-IIIs have  
5 a non-case-mix component to cover costs considered to be  
6 uniform across all patients such as room and board.

7           Now that I've discussed how the current payment  
8 system is adjusted for case-mix, I'll review some of its  
9 deficiencies that have been articulated by this Commission,  
10 GAO, CMS and other researchers.

11           The first of these is the omission of non-therapy  
12 ancillary costs such as prescription drugs and respiratory  
13 therapy from the determination of the RUG-III relative  
14 weights. Payments for non-therapy ancillary services are  
15 distributed using the same weights used to allocate payment  
16 for nursing care. To the extent that nursing staff time is  
17 not correlated with non-therapy ancillaries, payment for  
18 non-therapy ancillaries will not be distributed properly.

19           For example, two medications may differ  
20 substantially in cost but the staff time it takes to  
21 dispense the expensive drug and the inexpensive drug may be  
22 the same. In this case, payments to the SNF dispensing the



1 second expensive drug are not adjusted to reflect the higher  
2 cost of the medication. Instead, payments are distributed  
3 equally according to staff time.

4 This may lead to access or quality problems for  
5 certain residents, creates opportunities for favorable  
6 selection of residents, and can increase financial risks for  
7 providers.

8 Another criticism of the RUG-IIIs has been the  
9 classification of patients into rehab rugs according to  
10 services provided rather than patient characteristics. This  
11 can create incentives to provide therapy, especially because  
12 therapy RUGs are at the top of the payment hierarchy.

13 A third criticism has been the reliance of the  
14 case-mix system on the MDS. Research has questioned the  
15 validity and interrelated reliability of the MDS used to  
16 categorize patients. However, none of the options I'm about  
17 to discuss are going to have at all contemplated an  
18 alternative to the MDS.

19 Now I'm going to move on and review past research  
20 on refinements and some alternative payment options to the  
21 current SNF PPS, and I'm also going to review some other  
22 payment policy changes, outlier policy and per episode

1 payment that could be relevant to this discussion.

2 First, I'll review past work on efforts to refine  
3 RUG-IIIs to address paying for non-therapy ancillaries. CMS  
4 awarded a contract to Abt Associates in 1999 to review the  
5 RUG-III classification system with particular emphasis on  
6 the variation in non-therapy ancillary services within the  
7 RUG-III categories.

8 In their final report, the contractors recommended  
9 that CMS consider adding new groups to the RUG-IIIs for SNF  
10 patients who qualify for both rehab and extensive services  
11 categories because extensive services patients had much  
12 higher non-therapy ancillary costs. This proposal was  
13 called the RUG-III Plus model.

14 MS. BURKE: Can you give us an example?

15 MS. LINEHAN: An extensive services patient could  
16 be someone who is on IV meds receiving trach care. And  
17 because the MDS has the look back period it could be within  
18 the previous seven days or 14 days, ventilator or respirator  
19 patients, patients who require suctioning, patients who  
20 require IV feeding.

21 So the Abt researchers, in addition to proposing  
22 this RUG-III Plus model, also proposed applying one of two

1 index models to the new system. These indexes were  
2 developed from MDS items, such as suctioning, tracheostomy  
3 care and IV medication use, that were found to be  
4 significant related to per diem non-therapy ancillary costs.  
5 So residents would first be classified into one of the new  
6 RUG-III categories, and then assigned to another group  
7 within that based on the number of index variables that  
8 applied to them and the payment would be adjusted depending  
9 on --

10 MS. RAPHAEL: One question. If you are getting  
11 trach care or you're on a ventilator, you still are able to  
12 get rehab? Up to X hours in the nursing home?

13 MS. LINEHAN: Yes, I think so.

14 MS. RAPHAEL: I don't understand how you can fall  
15 in the both of those.

16 MS. BURKE: Range of motion.

17 MS. LINEHAN: It's physical, occupational or  
18 speech therapy so they're not necessarily getting physical  
19 therapy.

20 These recommendations were an attempt to maintain  
21 the RUG-IIIs structure but to better account for non-therapy  
22 ancillary costs. It did not alter the way patient were

1 categorized into rehab rugs according to services provided  
2 and it continued, as I said, to use MDS data.

3           Based on Abt's findings that this refined case-mix  
4 system had improved ability to predict variance in total and  
5 non-therapy ancillary costs, in April 2000 CMS issued a  
6 proposed rule to define the RUG-IIIs using this model. But  
7 in the July 2000 final rule, CMS announced the results of  
8 testing the models on post-PPS national level data. They  
9 found in the subsequent testing that these models did not  
10 improve the ability of the case-mix system to explain cost  
11 variance and therefore did not go through with the  
12 implementation of their proposed refinements. And as a  
13 result, the temporary payment add-ons remain in place.

14           In spite of the outcome of this particular  
15 refinement effort, an index similar in concept could be  
16 developed but additional research to identify variables that  
17 are better predictors of non-therapy ancillary costs would  
18 be required.

19           Now I'll discuss an entirely different  
20 classification system that was contemplated prior to the  
21 implementation of the PPS. Phil Cotterill at CMS tested the  
22 ability of a DRG-based case-mix index to predict Medicare

1 SNF patient resources at the facility level. Using DRGs  
2 derived from the SNF admission diagnosis, he found that  
3 although a significantly positive relationship existed  
4 between SNF costs and the SNF diagnosis-based index, the  
5 explanatory power in the SNF setting was weaker than the  
6 relationship between hospital costs and the hospital index.

7           Nevertheless, a DRG-based case-mix index may still  
8 hold some promise and appeal as an alternative payment  
9 classification system, especially if bundling with inpatient  
10 payment is being considered. Such a classification system  
11 would be based on patient characteristics rather than on  
12 services provided, a criticism of the RUG-III system. In  
13 addition, similar to what Abt researchers proposed in their  
14 RUG refinement, other variables such as measures of SNF  
15 patients' functional or cognitive status could be appended  
16 to the DRG to improve on its explanation of cost variance.

17           Still another model for your consideration is  
18 cost-based payment or partial cost-based payment. Some  
19 state Medicaid programs pay nursing home costs or certain  
20 kinds of costs subject to ceilings. This sidesteps the need  
21 to develop an adequate case-mix system altogether.

22           States may divide costs into different cost

1 centers, such as direct care, indirect care and  
2 administration and pay some centers prospectively and some  
3 others cost subject to certain limits. This presumably  
4 allows states to encourage spending in areas related to the  
5 product they want to buy and more tightly control spending  
6 in areas they don't necessarily want to pay more for.

7 But cost-based payment is inherently inflationary.  
8 For Medicare to adopt this type of payment system, the  
9 program might see a return to large increases in SNF  
10 spending like those prior to the implementation of the PPS.  
11 Given wider latitude to spend on direct patient care, it's  
12 also unclear whether facilities would target money to areas  
13 of patient care that can actually improve patient outcomes.

14 Finally, these last two features I'm going to  
15 discuss aren't necessary alternatives to the RUG-IIIs, but  
16 are common elements of other Medicare prospective payment  
17 systems and may be considered again in the SNF context.

18 The current Medicare SNF payment system does not  
19 have an outlier policy. Certain high costs in frequently  
20 provided services are currently excluded from the per diem  
21 rate but GAO concluded that CMS may not have consistently  
22 applied the criteria to exclude services from the payment

1 bundle and that perhaps still other services should be  
2 excluded as well.

3           An outlier payment may still be desirable,  
4 however, if there are cost outliers that a facility may be  
5 able to anticipate and avoid. Such a policy ideally does  
6 not undercut incentives for efficiency and encourages  
7 providers not to avoid especially costly cases. If an  
8 outlier policy were incorporated into the SNF payment  
9 system, a variety of design choices could be explored. For  
10 example, an outlier policy could be designed to compensate  
11 facilities for total cost outliers or for cases that have  
12 extreme costs in a single component of total costs on a per  
13 day or per stay basis.

14           And finally, the desirability of changing the unit  
15 of payment from a per day to a per stay payment may also  
16 warrant consideration. If a prospective payment system can  
17 be developed that has the ability to explain episode costs  
18 rather than daily costs for all patients or perhaps distinct  
19 subgroups of patients, then it might have the ability to  
20 promote efficiency better than a per day payment.

21           On the other hand, it's also important to weigh  
22 the potential consequences of a shortened length of a SNF

1 stay, and whether such a policy could potentially lead to  
2 adverse patient outcomes or otherwise avoidable use of  
3 inpatient hospital or other post acute care.

4 So this review of past research on SNF payment and  
5 the potential application of common PPS payment elements to  
6 SNF payment is intended to provide context for the potential  
7 directions that SNF payment modification might take.

8 We anticipate CMS's release of the BIPA mandated  
9 study on the SNF PPS alternatives and will bring these  
10 results to the Commission for consideration and continued  
11 discussion as they become available. In the meantime, we  
12 look for guidance from the Commission on any research on  
13 payment system alternatives you'd like to see moving forward  
14 into the spring and summer.

15 This concludes my presentation and I'll take your  
16 questions and comments.

17 MR. HACKBARTH: Questions?

18 DR. SCANLON: I'd like to expand on the discussion  
19 of cost base because I think we should consider it as an  
20 option in a slightly different context because when you talk  
21 about some states, it's actually about 45 that operate one  
22 of these kinds of systems. And in terms of its inflationary



1 potential, given that we hear so much about Medicaid as  
2 paying low rates, it would seem that it has some potential  
3 for controlling costs.

4           The big thing is that there's a major difference  
5 between the old Medicare system and what we're talking about  
6 with these state systems.

7           The two things that contributed most, probably, to  
8 the Medicare cost growth, was the fact that it was  
9 retrospective, and that the accounting principles allowed  
10 you to create a distinct part so that all you needed to do  
11 was to have a small number of beds that were dedicated to  
12 Medicare and you could keep books for those beds and then  
13 Medicare would pay the average cost of those beds.

14           When it's the average cost of the entire facility,  
15 your incentives are completely different. Your ability to  
16 incur extra cost and get them reimbursed are totally  
17 different. If you're 40 percent Medicare and you're paid on  
18 the basis of the average cost of the whole facility and you  
19 raise your cost of dollar, you have to ask yourself where's  
20 the other 60 cents going to come from because Medicare is  
21 only going to pay you 40. So it's a completely different  
22 kind of a situation that existed then.

1           And facilities were taking advantage of that.  
2   There were more distinct parts towards the end of the  
3   retrospective system than ever before. And you had  
4   companies with ancillary branches that were supplying  
5   ancillaries to themselves at inflated rates. This is what  
6   contributed to the bankruptcies that followed the  
7   introduction of the PPS.

8           So I think we're talking about a completely  
9   different world.

10           What is key in these is that they're still  
11   perspective systems. The issue is how often do you rebase?  
12   That influences how much inflation potential there is in one  
13   of these kinds of systems. That actually does create a need  
14   for a case-mix because you don't want a facility to be  
15   penalized because they admitted heavier care people over  
16   time and that today's costs are not in line with what they  
17   were two or three years before when they had a wider case-  
18   mix. So you really do want to think about that.

19           The other thing is that this is a variant of  
20   paying for performance. The research has shown a link  
21   between staffing in nursing homes and the quality of care.  
22   And states have said we would like our money to be more

1 directed towards staff. We want the nursing center to be  
2 more generously endowed and we want administration, more  
3 maintenance or things like that.

4 So you'll go into states where they will pay --  
5 the ceilings will be up to like the 76 percent dial on  
6 nursing and down at the median for administration. So it's  
7 a way of them directing their resources towards what they  
8 think is more important, in terms of the care being  
9 provided.

10 DR. MILLER: If I could react to a couple or ask a  
11 couple of those things. In the Medicaid world where this  
12 goes on, isn't the key point how frequently they allow the  
13 cost -- your rebasing point? Because the unvarnished  
14 statement of they have cost-based systems and you don't see  
15 costs going up in Medicaid is very much a function, I think,  
16 of how much the states are allowing that to go up. I have a  
17 string of things I want to ask.

18 The other thing I would ask you to comment on is  
19 the notion of paying for inputs versus outcomes. You were  
20 saying nursing ratios. Some of our conversations about  
21 quality have tried to be oriented towards what we're looking  
22 for

1                   And I guess the last thing is I definitely  
2 understand your point on the 40 cents on the dollar, but  
3 also what about cost allocations. Do we feel pretty  
4 confident with those kinds of issues in terms of whether  
5 Medicare could end up carrying more of the cost for other  
6 payers?

7                   DR. SCANLON: Going back to the first of your  
8 questions. The issue of the frequency of the update is a  
9 key here. The other thing that's different between the  
10 current Medicare system and these state systems is that  
11 there is an individual rate -- I'm sorry, a rate for each  
12 individual home. So it's a function of how they allocate  
13 their costs. As opposed to the Medicare system, which is  
14 based upon an average and your behavior does not affect your  
15 revenue. That's the key in terms of creating the greatest  
16 incentive to control your costs.

17                   When you start to link your own individual costs  
18 to your rate, obviously you weaken your incentive. But when  
19 you start to increase the amount of time between the date  
20 the rate is set and the date the costs are measured, then  
21 that incentive grows.

22                   Some states have actually also done things like to

1 avoid saying that we're going to use 2006 costs to set rates  
2 for a four year period, they will use a moving average of  
3 three years costs, so that they don't have people game them  
4 in that way.

5           Your second question about the idea of paying for  
6 outcomes as opposed to paying for inputs is totally valid.  
7 The issue is, as we faced when we were talking about pay for  
8 performance in SNFs, is the issue of measures. Even though  
9 there may be measures within the MDS that apply to the  
10 longer stay patient, there's also a feeling that we don't  
11 necessarily capture everything about a nursing home.

12           Nursing homes are individuals residences. In  
13 fact, in the long-term care field people dislike the term  
14 patient because these individuals are there for sometimes  
15 several years. This is their home. A lot of our measures  
16 are much more related to their health status, not to the  
17 quality of life that they are experiencing. And so the idea  
18 of putting more money into the things that seem to matter.

19           The nursing centers of the cost reports are  
20 typically rather broad. It's all the staffing. So it's not  
21 just the nursing staff in terms of registered nurse or LPNs.  
22 It's the aides that are doing a lot in terms of assisting

1 people with their activities of daily living. That's why  
2 states think that's important.

3           You could also argue wait a minute, isn't the  
4 housing aspect of life important, as well? I certainly  
5 wouldn't dispute that.

6           Your last point was the allocation. The  
7 categories are broad enough that I think that there's some  
8 potential, but I don't think it's extreme. It's relatively  
9 clear that people are doing care functions versus people are  
10 doing -- they're janitors or they're administrators. So you  
11 don't want it to be too fine about this. You don't want to  
12 try and have 10 cost centers. Having three or four is  
13 probably much more typical of what a state will do in terms  
14 of trying to skew the funds towards what they think of as  
15 more important.

16           MS. RAPHAEL: I don't know if I remember this  
17 correctly, but in one of the presentations I think we heard  
18 that, in fact, nursing staffing had not increased even  
19 though dollars had gone toward on this a number of ways. It  
20 could be that it had not increased because of shortages or  
21 other reasons. I don't recall the reasons.

22           But I do remember that one of the things that

1 struck me was that nursing staffing had not increased  
2 despite an infusion of dollars directed toward that.

3 DR. SCANLON: That was actually Medicare dollars  
4 and the issue was that there was a readjustment of the  
5 updates and nursing homes got a very significant increase.  
6 And Senator Grassley had made a request that the money be  
7 committed to staffing. It was not something that was  
8 required.

9 And then when GAO studied it, and I think did you  
10 look at it as well -- GAO looked at it and it was like a one  
11 minute increase per day or something like that.

12 MR. HACKBARTH: Others?

13 DR. WOLTER: I was thinking about the previous  
14 conversation on trying to move to one classification system  
15 for post acute care. And that does seem like a big  
16 challenge when there are other fundamental issues that  
17 aren't well defined.

18 But I'm wondering if in this work there's any  
19 opportunity to look at, if we're going to do some new  
20 classification of patients or look at defining acuity  
21 differently, are there some subgroups of patients that  
22 really are overlapping in hospital-based SNFs and LTCHs, and

1 could we do a little work on that as part of this work? Or  
2 maybe there's a similar overlap of subgroups with hospital-  
3 based SNFs, LTCHs and rehab hospitals, and could that be at  
4 least a step in the direction of trying to define ways that  
5 we could be following the patient rather than having very  
6 different payment systems in the separate silos.

7 So it might just be a step in the right direction  
8 if we could think about how we might design this work.

9 DR. MILLER: So the thought there, Nick, is that  
10 for some set of patients, say rehab, or some set of patients  
11 there might be an ability to cut them out and say there's a  
12 way that you can have a payment system that would get above  
13 these three different payment systems? Is that what you're  
14 thinking?

15 DR. WOLTER: The one that comes to mind, maybe  
16 mostly because of my own life and experience, is ventilator  
17 care where certainly in many parts of the country chronic  
18 ventilator care is delivered in hospital-based SNFs. Or  
19 maybe they're kept in the hospital setting, quite frankly,  
20 when there are LTCHs available.

21 MS. RAPHAEL: One other thing that I would like to  
22 see is a little more information on length of stay of



1 patients or residents in nursing homes. Not just the  
2 average but what the distribution looks like these days.  
3 Because I think that would help to think about an  
4 appropriate unit of payment and payment system.

5 MS. LINEHAN: We were hoping to look at that. We  
6 have a data set from CMS that links the inpatient stay with  
7 the SNF stay, and we were hoping to look at some of the  
8 trajectories of care and length of stay and that sort of  
9 thing. I hope we can undertake that over the summer.

10 MS. DePARLE: I'm interested in your comments  
11 about an outlier policy and whether that would be something  
12 that would help, at least in the short-term. First, is it  
13 possible to, in the short-term, develop an outlier policy  
14 that would be reasonable? And secondly, is that something  
15 that could help bridge the gap between what we think the  
16 current system is doing and where we think it should be?

17 MS. LINEHAN: I think it's a possibility, but we  
18 haven't done any work to show what the right sort of cut  
19 points would be or how this would redistribute payment or  
20 anything like that. So I can't answer it with any evidence  
21 of how this would look.

22 I don't know if the CMS report is going to address

1 this issue but they may have -- their contractor may have  
2 looked into this issue. So that's one thing we can hope  
3 for.

4 MS. DePARLE: When the PPS was first implemented,  
5 there was a lot of concern about consolidated billing and  
6 the issues around certain supplies and high-cost items. Is  
7 that still a concern? It isn't really something you raised,  
8 except with respect to some of the drugs, I guess.

9 MS. LINEHAN: I think initially there was nothing  
10 left out of the bundle. And then subsequently Congress  
11 excluded some services. And then CMS also administratively  
12 excluded some services from the bundle.

13 What precisely those area, I'd have to get back to  
14 you. But initially there was no exclusion at all. And then  
15 it was seen as a problem, I think, and then later addressed  
16 piecemeal.

17 MS. DePARLE: So it's not seen as a problem now?

18 MS. LINEHAN: The only thing that I've read about  
19 that was the GAO study that sort of looked at the  
20 application of the administrative exclusions and said that  
21 perhaps those weren't consistently applied and in that there  
22 might be other services. I don't know if they specified

1 that could be excluded.

2 MS. BURKE: Just following up on Nancy-Ann's  
3 question, I have considerable concern with respect to the  
4 suggestion that an outlier policy may make sense here as it  
5 has with respect to some of the other payment systems. And  
6 Nancy-Ann and Bill may have a better sense of this than I  
7 do.

8 But the outlier policies as we've developed them,  
9 particularly on the inpatient side, presume that we have a  
10 fairly good and fundamental understanding of the underlying  
11 payment system, that it is relatively accurate, and that the  
12 outliers attempt to capture some aspect of what can't be  
13 easily explained or is the unusual circumstance.

14 My concern here is the development of an outlier  
15 policy on what we believe, at least as I understand in your  
16 materials, to be a fairly fundamentally flawed system, that  
17 there are issues about the way the RUGs are structured, the  
18 failure to account for the variations in some of the non-  
19 therapy ancillary service costs, and the fact that it's  
20 basically based on a service rather than a patient  
21 characteristic.

22 So to presume that an outlier policy can be

1 developed assumes all of those things are fundamentally  
2 solid. And then it's just a question of adjusting as needed  
3 in unique circumstances.

4           So I worry about going very far in that direction  
5 and furthering essentially our failure to deal with the  
6 underlying question, which is does the underlying payment  
7 system make sense?

8           MS. LINEHAN: I think that's a good point and I  
9 think I mentioned that in my mailing materials, that if we  
10 think that there's a systematic problem with the non-therapy  
11 ancillary payments, it's probably more appropriately  
12 addressed by fixing the payment system rather than putting  
13 an overlay of an outlier policy to address it.

14           MS. BURKE: That's what I guess I was reflecting  
15 on is having read the document, I think Nancy-Ann having  
16 raised it, I do think we ought to underscore that as being  
17 less likely than some of the other possibilities in terms of  
18 future work. And I just wanted to support that basic  
19 statement, that it really does assume a fairly solid system.  
20 And I think we're pretty well agreed that it is a pretty  
21 flawed underlying structure.

22           DR. SCANLON: I would agree. We should have a

1 solid system. That should be the goal, number one.

2           Having done that, though. in terms of the non-  
3 therapy ancillaries, there's a question of whether all of  
4 them can be accommodated into a case-mix kind of adjustment  
5 or whether these exclusions are the appropriate kind of  
6 thing. Actually, when we looked at them in GAO, we had  
7 three criteria for thinking about exclusions. One is that  
8 they were rare and that would make it hard to create a class  
9 for them.

10           MS. BURKE: And it might appropriately go.

11           DR. SCANLON: Two, they were expensive. And  
12 three, they weren't gameable. And so if you met those three  
13 criteria, that was something that you may want to exclude.  
14 And you could call it an exclusion but in some respects it's  
15 an outlier, as well.

16           The other aspect of this system which maybe  
17 obviates the need for an outlier policy is the fact that  
18 it's a per day system. And so we deal with the fact that  
19 some people take longer to recover with the per day payment.

20           If we didn't change that, that again maybe says  
21 we're adequate. But we probably need to address the  
22 fundamental issues with the system first and then see where

1 we are in terms of outlier kinds of policies.

2 MS. BURKE: I guess part of my problem, Bill, is  
3 that you're absolutely right. One could define reasons for  
4 doing adjustments, the rarity of the event, the  
5 extraordinary size or degree of the difference.

6 I guess I think, in sort of the old way of why we  
7 did an outlier policy. It was the extreme. It was outside  
8 of what we thought were the ranges that were reasonable.  
9 And I thought of it less as an excluded activity than it was  
10 one where it was just an unusual and rare occurrence where  
11 it was too much or more of some thing that was already  
12 assumed in the base, rather than an adjustment that's an  
13 exclusion.

14 MR. HACKBARTH: Any others? Thank you.

15 And that was our last item before the public  
16 comment period.

17 And I've been sitting here thinking about the  
18 meeting today and I don't know about for you. This was hard  
19 for me. A lot of loose ends. I think part of the reason  
20 for that is that in my time on MedPAC now I've discovered  
21 distinct cycles that we go through. And when we first  
22 broach new issues I often have this feeling that we're not

1 getting anywhere, we're just throwing comments out on the  
2 table, I'm not sure where we go from here.

3 But we get through that phase and then it gets a  
4 lot easier as we start to crystallize the issues and can  
5 debate those more clearly and we have analysis to bring to  
6 bear.

7 We were that way back in January when we were  
8 doing specialty hospitals and the update factors and some of  
9 the other issues. We will get there again, I'm sure. But  
10 we need to persevere through this phase again.

11 Okay, we will have a brief public comment period  
12 and you know all of the ground rules very well from past  
13 experience, so please keep your comments brief. Thank you  
14 very much.

15 MS. SMITH: My name is Elise Smith and I'm with  
16 the American Health Care Association.

17 I just wanted to correct one fact here.  
18 Commissioner Scanlon, you referred to a GAO study on the  
19 forecasting, the correction of the market basket because of  
20 poor forecasting. This is known as the forecasting  
21 correction.

22 That has happened within the last two years.

1 There is no report out yet from the GAO or the OIG, but it  
2 is on the agenda, I believe, of the OIG. I think what you  
3 were referring to was the 16 percent addition to the nursing  
4 component and that the GAO did a study on that.

5 We responded to that study. We had problems with  
6 the time period, the length of time after the receipt of the  
7 16 percent increase in that component, it was a temporary  
8 increase, and some other issues we raised. And we are very  
9 appreciative of the fact that MedPAC did acknowledge some of  
10 the points that we had made.

11 I think the increase in staffing was not as de  
12 minimus as you had thought or had provided, but I cannot  
13 remember any numbers.

14 I have only one other point. The issue raised on  
15 consolidated billing, there is one remaining issue in  
16 consolidated billing -- well, there are more than one  
17 remaining issues. But a very important one, and I think  
18 especially to rural communities, and that is the site of  
19 service issue. In order for services like MRIs or radiation  
20 therapy to be excluded, the SNF must take the patient to a  
21 hospital, even if there is any kind of freestanding clinic  
22 closer to the home, the exclusion will not apply.



1           This is an increasing problem that we believe can  
2 be corrected administratively, but I believe it is CMS's  
3 position that we would have to pursue legislation. We have  
4 found out that this is a problem that is increasing in rural  
5 areas.

6           Thank you.

7           MS. WOODY: Hi, my name is Yara Woody and I'm with  
8 the American Association of Homes and Services for the  
9 Aging.

10           I would like to call on the last presentation and  
11 bring first the idea of cost-related payments as an option  
12 for revising SNF PPS. We, at AAHSA, want to make sure that  
13 the Commission understands that a cost-related system does  
14 not necessarily mean that we're going back to the old days  
15 of retrospective cost reimbursement system.

16           Currently most state Medicaid programs use a  
17 prospective modified cost-related payment system that better  
18 targets direct care spending and hence improves quality.  
19 These modified cost-related systems have been empirically  
20 verified to work as they were intended to work and states  
21 using these payment systems have higher nursing staffing and  
22 better quality care than states that use the flat rate like

1 with the Medicare system right now.

2 This is not to say that the amount of Medicaid  
3 payment is appropriate or adequate, but instead we just  
4 wanted to emphasize that much can be learned from these  
5 payment systems.

6 There are numerous studies that support this idea  
7 and as the Commission considers SNF PPS and pay for  
8 performance, we urge that you look further into this  
9 modified cost-related payment structure has an option for  
10 improving the SNF PPS.

11 Thank you.

12 MR. HACKBARTH: Okay, we're adjourned until 9:00  
13 o'clock tomorrow.

14 [Whereupon, at 4:54 p.m., the meeting was  
15 adjourned, to reconvene at 9:00 a.m., Friday, March 11,  
16 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 11, 2005  
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
SHEILA P. BURKE  
FRANCIS J. CROSSON, M.D.  
NANCY-ANN DePARLE  
ARNOLD MILSTEIN, M.D.  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
CAROL RAPHAEL  
WILLIAM J. SCANLON, Ph.D.  
DAVID A. SMITH  
RAY A. STOWERS, D.O.  
MARY K. WAKEFIELD, Ph.D.  
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: I'd like to welcome our guests,  
3 Peter Neumann and David Eddy. I've long enjoyed reading  
4 your many writings on this subject. It's one that I've been  
5 interested in for a long time, since I served in HCFA back  
6 in the mid-1980s and we tried to do some things on this  
7 front. Unsuccessfully, but we tried.

8 Nancy, I think you're going to do the formal  
9 introduction.

10 MS. RAY: Good morning. Recall last month we  
11 began to discuss issues surrounding Medicare's use of  
12 information about clinical and cost-effectiveness when  
13 making coverage decisions and also in the rate-setting  
14 process. This month we've brought two experts and if they  
15 are going to give their perspective and talk a little bit  
16 about their research on these topics.

17 Our first speaker is Dr. David Eddy. Dr. Eddy is  
18 a physician and a mathematicians and an independent  
19 consultant living in beautiful Aspen, Colorado. Dr. Eddy is  
20 also senior adviser for health policy and management at  
21 Kaiser, and chief scientist at the Blue Cross-Blue Shield  
22 Kaiser technical evaluation and coverage program.

1           Dr. Eddy wrote the first national guideline  
2 explicitly based on evidence, wrote the seminal paper on the  
3 role of guidelines in medical decision-making, wrote the  
4 first model applied to clinical problems, and wrote the  
5 original criteria for coverage decisions, and was the first  
6 to use and publish the term evidence based. Dr. Eddy is  
7 author of five books and more than 100 first authored  
8 articles, and he also has a series of essays for the Journal  
9 of the American Medical Association.

10           Our second speaker is Dr. Peter Neumann. Dr.  
11 Neumann is associate professor of policy and decision  
12 sciences in the Department of Health, Policy and Management  
13 at the Harvard School of Public Health in snowy Boston. His  
14 research focuses on the role of cost-effectiveness analysis  
15 in health care decision-making. He has conducted numerous  
16 economic evaluations of medical technologies, including an  
17 evaluation of treatment for Alzheimer's disease. He also  
18 directs a project that is developing a comprehensive  
19 registry of cost-effectiveness analyses in health care.

20           Dr. Neumann has contributed to the literature on  
21 the use of willingness to pay on quality-adjusted life  
22 years, QALYs, in valuing health benefits. Dr. Neumann is

1 the author of a recent publication, a book, Using Cost-  
2 effectiveness Analysis to Improve Health Care, and he is  
3 contributing editor of Health Affairs and president-elect of  
4 the International Society for Pharmacoeconomics and Outcomes  
5 Research.

6 Dr. Eddy will start and then Dr. Neumann will  
7 conclude and then they'll be able to take your questions and  
8 answers.

9 DR. EDDY: Thank you very much, Nancy, Glenn, and  
10 commissioners. I'm very pleased to -- I thank Nancy, Glenn,  
11 and the commissioners for inviting me to come and discuss  
12 this really very interesting and obviously extremely  
13 important topic. I'm delighted that you're taking this on.  
14 It's a problem that needs your attention and I'm really  
15 looking forward to your efforts to try to bring some  
16 rationality and effectiveness to this kind of approach to  
17 the kinds of decisions that have to be made in the Medicare  
18 and Medicaid programs.

19 I'm going to move through my slides pretty  
20 quickly. Most of them speak for themselves, and also you  
21 know the answers to most of the questions that I'm posing  
22 here. But Nancy suggested several questions to me when we

1 talked on the phone so I've tried to go through this list.  
2 The first was, should CMS consider costs in its decisions  
3 and my answer is a simple, yes, I think it should.

4           Down at the bottom there the bullet you see a duh.  
5 I should have put that in parentheses to be a little bit  
6 more gentle, but the thought is that we obviously have a  
7 cost problem and you can't control costs without considering  
8 costs. To me that's the end of the story. If we're trying  
9 to design an efficient system that maximizes the quality  
10 that we are delivering for a given budget, you have to  
11 consider the budget side of that equation. So I don't see  
12 any way to escape it and I feel that until we do address it  
13 and do it in a reasonable way we are never going to solve  
14 our cost-quality problems in health care in the United  
15 States. That was fairly blunt.

16           Now the question is how CMS might use cost-  
17 effective information and there are obviously lots of  
18 different ways. I've just listed a few on this slide. The  
19 most obvious perhaps is to decide coverage decisions and  
20 perhaps withhold coverage for things that are "not cost-  
21 effective." But there are a lot of other ways to do it as  
22 well and there's no reason why all of these have to be done.

1 So you, I think, can pick and choose from this list.

2 Another way is to decide the amount that you're  
3 going to pay for a new technology, to set priorities for  
4 disease management strategies, to design performance  
5 measures, guidelines, pay for performance programs, and  
6 things of that nature. As you can appreciate, some of these  
7 are much more visible than others. Some will be more  
8 acceptable than others and so forth. But I think it's  
9 important to keep the entire list in mind.

10 The next question was whether or not the use of  
11 cost-effectiveness analysis could harm beneficiaries, and  
12 that depends on whether you're talking about the health  
13 effects or the cost effects. We have to admit that health-  
14 wise, yes, it could hurt beneficiaries a little bit because  
15 by its very nature it makes trade-offs. It looks at whether  
16 or not the magnitude of benefit to be gained from the  
17 technology is "worth its cost" and makes some hard decisions  
18 and it will conclude in some cases that the magnitude of the  
19 benefit simply isn't big enough to justify the cost. So the  
20 people who would have gotten that procedure will lose.

21 On the other hand, we just need to accept that  
22 because, as I say, that's a very nature of making difficult



1 decisions, and it also fits well within lots of other  
2 decisions that we already made where we trade off health  
3 benefits versus costs.

4           The next slide was whether or not the use of cost-  
5 effectiveness analysis would help beneficiaries, and in  
6 terms of the cost of care it should help it a lot, because  
7 if we did take costs into account in making some of these  
8 decisions, then by definition we're going to have a more  
9 efficient, more effective program and that's in the interest  
10 of everyone, I think.

11           Now the question is going to be whether the trade  
12 off of benefits versus costs is worth it, in some sense, and  
13 cost-effectiveness analysis, if done correctly, by  
14 definition means that it will be worth it. If the trade-off  
15 is not worth it then you don't make the trade-off. You only  
16 make the trade-off if the trade-off is deemed to be worth  
17 it. So by definition all people in general, the population,  
18 if you will, will come out ahead if cost-effectiveness  
19 analysis is used properly.

20           Will it hurt innovation? I think yes and no. It  
21 will hurt the innovation of technologies that are not cost-  
22 effective. On the other hand, it will stimulate the

1 development and help the development of technologies that  
2 are cost-effective. That is, it will put a new signal into  
3 the marketplace in the same way that things that like  
4 emission controls have put a signal into the marketplace and  
5 it will cause people who develop medical technologies to do  
6 them in a way that are in fact cost-effective.

7           What are the problems with using cost-  
8 effectiveness analysis? There are several. One is the law  
9 and I'm not going to say much about this because there are  
10 lots of people in this room who know a lot more about how  
11 the law applies to cost-effectiveness analysis and what you  
12 are and are not able to do. But we have to admit that there  
13 are very important legal issues that need to be taken into  
14 account and I will leave that to others to comment on.

15           Another very important problem is the politics.  
16 We know that cost-effectiveness analysis is very unpopular  
17 with some very vocal groups. This is an appropriate way  
18 that society makes its decisions, but we can expect as much  
19 resistance to the application of cost-effectiveness analysis  
20 today as it has received in the past. People or  
21 organizations, corporations that promote technologies that  
22 may or may not, or possibly will not make the grade in a

1 cost-effectiveness analysis will, I put up here, scream. I  
2 should have softened that a little bit. They'll argue.  
3 Beneficiary groups might scream. The benefits in terms of  
4 lower taxes and lower costs accrue to different people than  
5 the current beneficiaries. And the benefits tend to be much  
6 more spread out, and the people who receive them are much  
7 less visible than the organizations or individuals who might  
8 claim that they are being harmed.

9           So all of this creates a very difficult political  
10 issue. I have no magic answer to that except to say we  
11 would try to apply cost-effectiveness analysis in a way that  
12 helped everyone to understand that in fact it will improve  
13 the public in the long run if it is done correctly.

14           Now there is another class of problems that I  
15 think it's important you understand. This really gets  
16 closer to my personal area of experience and so forth. I  
17 say this with a little bit of hesitancy because I don't want  
18 to discourage you from using cost-effectiveness analysis.  
19 On the other hand, I believe that you should be fully  
20 informed, at least of the world as I see it, in terms of the  
21 methods of cost-effectiveness analysis.

22           There are several methodological problems that I

1 believe need attention. One is that the state-of-the-art of  
2 modeling, I don't believe, right now can uniformly be  
3 assumed to give correct and accurate answers. I'll give  
4 more information about that in a moment. In fact the last  
5 three bullets on this slide address that. In fact very few  
6 models in use for cost-effectiveness analysis have been  
7 validated and there is good evidence, strong evidence, and  
8 I'll show you some in a moment, that different models give  
9 different answers to the same question. So just depending  
10 on which model you happen to be using, which group happens  
11 to be doing it, possibly what the objective of the analysis  
12 is, you could easily get different answers to the same  
13 question. And when you get an answer, unless we're very  
14 careful and design a system that will help us understand  
15 which answer is correct, it can be very difficult to  
16 determine whether or not the cost-effectiveness that has  
17 been calculated is in fact an accurate reflection of what  
18 will happen in reality.

19           Now I'm going to give you some examples. This is  
20 an exercise in which seven modeling groups modeling diabetes  
21 got together. They've been getting together for several  
22 years now. They agree on a standardized problem. They keep

1 it as simple as possible, and then they all do a calculation  
2 of the effectiveness, the cost, and the cost-effectiveness.  
3 So it's an excellent opportunity to, if you will, compare  
4 how similar or dissimilar different modelers can be in terms  
5 of the results that they produce.

6 I'm giving you one example. This is an example  
7 that has been used for two years in a row because the first  
8 year the answers were quite discouraging so they decided to  
9 sharpen the assumptions and try again the second year. So  
10 I'm showing you the after picture, if you will, not the  
11 before picture.

12 This is a particular case, a 65-year-old white,  
13 European male who's had diabetes for five years. You can  
14 see the other results on this slide. The point is that  
15 define a very specific person and they ask each model to  
16 calculate the chance that this person will have important  
17 outcomes like heart attacks and so forth. You can see on  
18 the bottom sub-bullet there, there are at least 28 different  
19 assumptions or details that were specified about this  
20 patient to try to make certain that all the models were  
21 going to analyze the same question.

22 I should also point out that each of these models

1 had a common root. They all come out of a single model, and  
2 they all use the same sub-model for calculate heart attacks.  
3 It's a mark off model and for that particular transition  
4 probably they're all using the exact same sub-model. So  
5 these are highly inbred.

6 Here are the seven models' answers of the chance  
7 that this particular patient on the previous slide will have  
8 a non-fatal heart attack. You can see that the answers are  
9 all across the board. Depending on which model you use you  
10 could get answers that vary by a factor of almost five. So  
11 you have to wonder what is the -- it's absolutely certain  
12 that not all of these models are correct because they're  
13 all giving different answers, and it just begs the question  
14 of which one, if any of them, is correct and how you would  
15 determine what the correct answer is.

16 Now that's the chance of all heart attack. In  
17 cost-effectiveness analysis we're interested in the effect  
18 of a treatment in reducing the chance of a heart attack, or  
19 an important outcome. In this particular case they  
20 specified that each modeling group should use the exact same  
21 treatment, which would lower the hemoglobin A1c, a measure  
22 of glucose control, from 10 to 8.5 percent. So they're

1 looking at the exact same treatment, and these are the  
2 answers they got. In some cases the effect of the treatment  
3 was to reduce the chance of a heart attack by almost 5  
4 percent. One model actually showed that it might increase  
5 the chance of a heart attack. So here you see differences  
6 on the order of two or three, something like that.

7 I don't have to point out to you that a little  
8 tiny shift in the estimated probability of an outcome or the  
9 effect of a treatment on the chance of an outcome can have a  
10 huge effect on the cost-effectiveness that you calculate,  
11 especially when you project this out over a 70-year period  
12 or something like that, which is what you need to do if  
13 you're going all the way out to life expectancy.

14 They also addressed costs. They made the same  
15 assumption about the cost of the treatment, \$300 a year, and  
16 these are the estimates they got of the cost of the  
17 treatment. So this is the cost part of the cost-  
18 effectiveness equation. Again you see answers that range  
19 enormously. It looks like a factor of about seven there  
20 when you compare model two versus model three.

21 Then finally in terms of cost-effectiveness  
22 analysis, after agreeing that they would all use the exact

1 same assumptions for the quality weights that should be  
2 assigned to various outcomes, they produced this. Some  
3 showing that it would save money, two showing that it would  
4 cost money, and there's a wide difference there.

5           Now you might be impressed that they're all fairly  
6 low. I'll just tell you that if you change the problem,  
7 change the patient, change the treatment or anything else,  
8 that Y axis, if you will, the vertical axis could change  
9 enormously and these numbers could be going from minus  
10 \$20,000 to plus \$100,000 and so forth. The point is that  
11 these models are giving extremely different answers to the  
12 essentially the same question.

13           Now in an attempt to alert people to the  
14 uncertainty that can occur in a cost-effectiveness analysis,  
15 modelers have a variety of techniques. I think one of the  
16 most useful is to take all of the assumptions of the  
17 modeler, or at least all the important ones, put probability  
18 distributions on each one of the assumptions and then do a  
19 Monte Carlo analysis to get a feeling of the range of  
20 uncertainty about the answer across individuals. But I fear  
21 that that doesn't work.

22           Here's an example of that. This is a slightly



1 different problem but it will still illustrate the same  
2 point. So it's not patient three, which I showed you  
3 before, it's an analysis of -- actually it's not diabetes  
4 prevention. It is cholesterol treatment in people with  
5 diabetes. In any event, on this bar you can see the error  
6 bars, at least you can see the upper part of the error bar  
7 poking out the top, and if you look closely you'll see the  
8 bottom part of the error bar sitting in the bar part of the  
9 bar. So the thought is that while the model might be  
10 uncertain, it might make a best guess that the cost for  
11 quality for this particular program is on the order of  
12 \$24,000. It's admitting that there's some uncertainty  
13 saying it could be as low as about \$22,000 and could be as  
14 high as about \$28,000.

15           The problem is that that range doesn't capture any  
16 of the results of any of the other models that worked on the  
17 exact same problem. If I take model one, which is the one I  
18 showed you on the previous slide -- this slide, it's a  
19 little bit difficult to compare because I've changed the  
20 limits on the Y axis, but in the bold lines there going  
21 horizontally I've shown you the upper and lower bounds where  
22 modeling group number one thinks, I might not be exactly

1 right but I'm pretty darn sure it lies within those bold  
2 lines. You can see that none of the other four groups have  
3 answers that actually lie within the bold lines. So I don't  
4 think that the current methods we have for trying to assess  
5 the degree of uncertainty about a model's results so far  
6 have solved the problem.

7           But I do think the problem can be fixed, and the  
8 way to fix it I believe is to anchor models to reality.  
9 That is, ask that models do calculations that simulate real  
10 experiences that have happened in real populations and  
11 compare the model's results to the real results. I can show  
12 you an example. This is just an example. I'm expecting  
13 that other models either can now or will be able to do this  
14 so I'm not trying to push this particular model.

15           For example, you might ask the model to analyze a  
16 problem that has in fact been studied in a real randomized,  
17 controlled trial, and ideally the model will not have seen  
18 the trial before when it does the calculation. So this is  
19 an Archimedes calculation of the effect of simvastatin in  
20 high risk people. On the left we have the outcome, the  
21 probability of a heart attack in the control group, and on  
22 the right we have the probability of a heart attack in the

1 treated group, and the error bars are shown there for the  
2 calculation.

3           What we can do is compare that to what actually  
4 happened is the real 4S trial in this particular case,  
5 because that's the trial we're trying to simulate. So I  
6 think if models do this kind of thing, then you get a  
7 feeling that the model in fact can and has reproduced  
8 reality and you get a better sense of confidence that when  
9 you hand it a new problem it will be accurate. Especially  
10 if you do this over and over and over again. The two sets  
11 of bars on the left are the Helsinki heart study, the two  
12 middle bars are the systolic hypertension something or other  
13 program -- I've forgotten. 4S you've already seen, that's  
14 on the right. The heart protection study, deaths, major  
15 coronary arteries, the Hope study, Care, so forth and so on.  
16 You keep doing this over and over again and you get a sense  
17 that the model in fact is anchored to reality.

18           For this particular model we've done this over 100  
19 times now with only two cases in which the model's answer  
20 falls outside of the confidence intervals for the real  
21 trial. As you know, there's a lot of uncertainty about the  
22 real trial as well.

1           So I would propose that we push models in this  
2 direction and ask them to show this kind of evidence that in  
3 fact they match reality before we begin to place a high  
4 degree of confidence on them for a new problem. There's  
5 more here, lipid and so forth. If anyone is interested,  
6 this has all been published and I can get the references to  
7 you.

8           I'm closing now with a list of things that I  
9 think CMS would need in order to pull off the inclusion or  
10 incorporation of cost-effectiveness analysis in its  
11 decisions. One is, it addresses the problem that I posed in  
12 the previous four or five slides, and that is, I do think  
13 that it would be important to have explicit criteria or a  
14 checklist of things that document the validity of a model.  
15 I just think that's extremely important. I think it's long  
16 overdue.

17           I think that there will have to be a standardized  
18 list of costs, otherwise different modeling groups can just  
19 use different costs. I'm not saying they'll do it  
20 intentionally but they'll end up using different costs and  
21 come out with different answers simply because they have  
22 different assumptions on costs. And the same message

1 applies to the measures of effectiveness or quality, such as  
2 the quality weights that you put on various outcomes.

3           Then finally we have to have criteria for  
4 determining what cost-effectiveness is or it isn't. I know  
5 you're all aware of the NIC in England which sets a  
6 particular threshold and asks comparisons to be made to  
7 that. If there is to be a threshold like that then I think,  
8 obviously, enormous care has to be paid to exactly what the  
9 threshold ought to be, and that might be something --I'm  
10 expecting Peter might well talk about this and it might be  
11 something that will come up and I'll add more comments  
12 later.

13           Then I'll close by going back to one of the  
14 earlier slides which is where CMS might start to apply cost-  
15 effectiveness analysis. You remember this list. I'll just  
16 say that they are not all equally easy to do in a political  
17 sense. I think that coverage decisions are far and away the  
18 most visible and that would be a difficult place to start  
19 for political and perhaps result legal reasons. But there  
20 are other ways that you can get cost-effectiveness analysis  
21 into decision-making in an important way, such as deciding  
22 the amount of payment, setting priorities, designing disease

1 management programs, setting performance measures, designing  
2 pay for performance, and things like that.

3           So for example, many of these point the finger at  
4 certain activities that are very important to do. You can  
5 make sure that those are cost-effective activities. If  
6 they're activities that are not cost effective, you just  
7 don't point your finger at them with a pay-for-performance  
8 program or a performance measure or a guideline or something  
9 like that. I think this would prove to be a more acceptable  
10 way to get cost-effectiveness analysis in.

11           Then finally I'll say that I hope you do it,  
12 because we really, really need some way of incorporating  
13 cost in our decisions. Our health care system is out of  
14 control in ways that you know much better than I do, and I  
15 think an integral part of solving that problem would be to  
16 add cost into the equation for how we decide what was we're  
17 going to do and how we're going to do it.

18           Thank you very much.

19           DR. NEUMANN: Thank you very much, Mr. Chairman,  
20 members of the Commission, for your invitation to speak  
21 today on the important subject of the use of cost-  
22 effectiveness information by the Medicare program. I'm also

1 delighted that you're taking this on, and also want to say  
2 I'm delighted and honored to appear here with Dr. Eddy who  
3 has contributed so much to the field.

4 We'd all like the Medicare program to obtain good  
5 value for its expenditures in paying for drugs, devices and  
6 procedures. In my remarks today I'd like to discuss how the  
7 use of cost-effectiveness analysis can help us in this goal.  
8 I'll touch upon four issues.

9 First, a little bit about the cost-effectiveness  
10 paradigm and the advantage of using formal cost-  
11 effectiveness analysis to help us achieve better value.

12 Second, some illustrations about what  
13 interventions are and are not cost-effective for Medicare.

14 Third, my own thoughts about limitations of cost-  
15 effectiveness analysis and why the Medicare program hasn't  
16 used this technique, despite some previous attempts to do so  
17 and despite the fact that it is used by health reimbursement  
18 authorities in many countries worldwide.

19 Finally, I'll conclude with some discussion of  
20 ways in which we might move the system towards one that uses  
21 cost-effectiveness analysis, and hence, reflects value-based  
22 purchasing.

1           The field of cost-effectiveness analysis and  
2 economic evaluation of health and medicine more generally  
3 has been an active area of research for many years, as  
4 researchers refine methods to quantify the clinical and  
5 economic consequences of using health care. This slide  
6 shows we can conceptualize the impact of any intervention in  
7 terms of its impact on costs and on health. Cost-  
8 effectiveness analysis shows the relationship between the  
9 total resources used, costs, and the health benefits  
10 achieved, effects, for an intervention compared to an  
11 alternative. In the words, where are we on this cost-  
12 effectiveness plane?

13           Often a standard metric such as life years, or  
14 quality-adjusted life years gained, QALYs, is used as the  
15 measure of health benefits. Consensus panels, including the  
16 U.S. Panel on Cost-Effectiveness in Health and Medicine have  
17 recommended using the standard metric cost per QALYs for  
18 purposes of comparing diverse conditions and treatments.

19           On this slide an intervention in quadrant one  
20 would decrease health and increase costs. An intervention  
21 in quadrant four, on the other hand, would increase health  
22 and decrease costs. An intervention in quadrant three would



1 decrease costs and health. Typically, with new technology  
2 we're in quadrant two. The new technology increases net  
3 cost but also increases health.

4 We might have a technology, example, that results  
5 in a net cost per QALY of \$20,000, which most people seem to  
6 view as relative good value for money. Alternatively, we  
7 might have a new technology that results in net costs of  
8 over \$100,000 for every QALY gained. That is, it's much  
9 more expensive to produce health.

10 What interventions might be cost-effective for  
11 Medicare? Here are some illustrations. This study suggests  
12 the flu vaccines, for example, save net costs and improve  
13 health. Some interventions increase net costs but still  
14 represent good value for money. Some examples include beta  
15 blockers after MI, under \$10,000 per QALY; cholesterol  
16 management with statins for secondary prevention, \$10,000 to  
17 \$50,000 per QALY.

18 Other interventions with cost per QALY ratios in  
19 the \$50,000 to \$100,000 for QALY range. For example,  
20 dialysis for end-stage renal disease. There are also  
21 examples of interventions with cost per QALY ratios above  
22 \$100,000 including technologies recently covered by

1 Medicare; lung volume reduction surgery, left ventricular  
2 assist devices, PET for Alzheimer's disease.

3           Data like these underscore several important  
4 points about the cost-effectiveness of medical technology.  
5 First, a great deal of information like this has become  
6 available to policymakers. Unlike many unsupported  
7 assertions made about the cost-effectiveness of drugs and  
8 other medical technologies, these studies quantify costs and  
9 health effects using data and a standard, well-accepted  
10 methodological technique.

11           Second, according to many peer-reviewed articles,  
12 many interventions, including many technologies are indeed  
13 cost-effective. These interventions provide good in the  
14 sense that they provide health benefits for relatively  
15 little cost or actually save money for the health care  
16 system sometimes despite high price tags.

17           Third, cost-effectiveness does not mean cost  
18 savings. Over the years people have sometimes confused  
19 these terms. But restricting the term cost-effectiveness to  
20 cost-saving interventions would exclude many widely accepted  
21 interventions which do not save money but are cost-effective  
22 in the sense that their additional benefits are worth the

1 additional costs.

2           Fourth, a discussion of medical technology's cost-  
3 effectiveness needs to include a specific description about  
4 how the technology is used and on whom. A technology or in  
5 any intervention is not intrinsically cost-effective or  
6 cost-ineffective. It is only meaningful to say that a  
7 technology is cost-effective compared to something else. A  
8 drug prescribed to lower an individual's blood pressure may  
9 in fact be cost-effective compared to the option of no  
10 treatment but not necessarily cost-effective compared to an  
11 alternative intervention such as an intensive program of  
12 diet, exercise, or other medication.

13           In addition, claims of cost-effectiveness often  
14 depend on the population under investigation. For example,  
15 statin drugs used to lower individual's cholesterol have  
16 been found to be relatively cost-effective as secondary  
17 prevention in persons with existing heart disease, but  
18 considerably less cost-effective as primary prevention.

19           Finally, in the third column of this slide I have  
20 provided some rough estimates on the degree to which the  
21 Medicare population is actually using these technologies.  
22 For example, roughly 40 to 70 percent of beneficiaries

1 receive flu vaccine, 85 percent receive beta blockers post-  
2 MI, 30 percent receive statins for secondary prevention, 90  
3 percent receive dialysis. This slide also shows projections  
4 of use of certain technologies with high cost-effectiveness  
5 ratios, including lung volume reduction surgery, left  
6 ventricular assist devices, and PET for Alzheimer's disease.  
7 While these estimates are rough, the point is that using  
8 cost-effectiveness analysis we can identify possible areas  
9 for reallocation from less efficient uses of resources to  
10 more efficient ones, in the process, obtaining more overall  
11 health for our Medicare dollars.

12           Why doesn't Medicare use cost-effectiveness  
13 analysis? Logically one might expect them to do so. How do  
14 we explain this paradox, cost-effectiveness information  
15 provides a useful analytic tool yet payers like Medicare are  
16 not using it? There are several theories about this, some  
17 of which Dr. Eddy touched upon and I'll discuss as well.

18           One is that we mistrust the methods. Dr. Eddy  
19 spoke about this and researchers have long observed that  
20 many published cost-effective analyses do not adhere to  
21 recommend protocols for conducting and reporting analyses,  
22 and that different models may come to very different

1 conclusions. A related problem pertains to a perceived lack  
2 of relevance. Observers point to a disconnect between  
3 abstract societal perspective taken by many published  
4 studies and the short-term horizons of many actual decision-  
5 makers.

6 Another explanation questions not the methods of  
7 CEA but the motives of investigators and/or their sponsors.  
8 On the one hand, CEA is seen as a smoke screen for cost-  
9 cutting efforts, and sometimes, conversely, as an advocacy  
10 tool by those with a financial gain at stake to increase  
11 health expenditures.

12 Another explanation mentioned by Dr. Eddy points  
13 to legal and regulatory barriers. That is, decision-makers  
14 are afraid they'd be sued if they withheld an effective  
15 technology because of its high costs, or that Medicare rules  
16 prohibits its use. But each of these explanations, I'd  
17 argue, falls short.

18 Mistrust of methods and motives undoubtedly plays  
19 a role. Still why haven't policymakers in the U.S. funded  
20 or conducted their own analyses or tailored them to their  
21 own needs as they have in other countries?

22 Legal and regulatory factors also fail as a full

1 explanation. Nothing in federal statute explicitly bars  
2 Medicare from using cost-effectiveness analysis. While  
3 health plans and doctors may fear lawsuits if they use cost-  
4 effectiveness analysis openly, there are also plausible  
5 reasons to believe that health plans could withstand these  
6 challenges as they have withstood challenges to other cost-  
7 containment initiatives.

8           The best explanation seems to be that at its roots  
9 the resistance to cost-effectiveness analysis is grounded  
10 not in methodological or legal barriers but in Americans  
11 deep-seated distaste for explicit rationing. Other  
12 countries' acceptance of cost-effectiveness analysis  
13 confirms that our failure is driven more by our own  
14 cultural, political, institutional conditions rather than  
15 the techniques' inherent methodological shortcomings.

16           A final thought. Why would analysts continue  
17 publishing studies in the literature if the information is  
18 being ignored? It is possible that we are using cost-  
19 effectiveness analysis, but quietly, under the radar. Cost-  
20 effectiveness analysis may actually enjoy some influence in  
21 the U.S., not as an explicit instrument for prioritizing  
22 health services but as a more subtle lever on policy

1 discourses. Cost-effectiveness information may influence  
2 clinical guidelines, formulary policy, even Medicare  
3 coverage to some extent, Medicare coverage payment coding  
4 decisions and so forth, but not in a direct or open way.

5           Finally, I would end by offering five observations  
6 as we look ahead.

7           First, cost-effectiveness analysis should be used  
8 flexibly. Leaders in the field have always warned against  
9 using it mechanically and experience teaches us that rigid  
10 use of cost-effectiveness analysis will likely be resisted.  
11 Cost-effectiveness analysis should inform decisions, not  
12 dictate them, and there may be selected opportunities to use  
13 them. For example, in covering preventive services, or as  
14 Dr. Eddy mentioned, in informing payment policy. We might  
15 even apply different cost-effectiveness thresholds in  
16 different contexts or account for other important factors  
17 such as access and equity.

18           Secondly, cost-effectiveness analysis may or may  
19 not save money. Cost-effectiveness analysis is not really a  
20 cost-containment tool, but rather a technique to improve  
21 value. Indeed, wider use of cost-effectiveness analysis  
22 would likely uncover examples under-utilized services that

1 increase costs but represent good value for money, as well  
2 as cost-ineffective and over-utilized services. Whether  
3 cost-effectiveness analysis save money will depend on how  
4 generously or strictly policymakers apply the cost-  
5 effectiveness threshold.

6 Third, process matters. The process for using  
7 cost-effectiveness analysis will be important. Transparent  
8 procedures with appeals to the best scientific evidence and  
9 models, and opportunity for public comment and stakeholder  
10 participation will be very important. CMS has developed a  
11 more open and rigorous process for scrutinizing clinical  
12 evidence in recent years for its national coverage  
13 decisions, for example, which could serve as a model for  
14 future deliberations about cost-effectiveness analysis.

15 Fourth, the incentive in the system matter a great  
16 deal. Debates about the use of cost-effectiveness cannot be  
17 separated from debates about the underlying health care  
18 system and the incentives it embodies. How to reconfigure  
19 these incentives facing providers and patients is a related  
20 critical challenge.

21 Finally, will get harm innovation? Some have,  
22 perhaps understandably, expressed concern that adoption of



1 cost-effectiveness analysis will impede innovation of  
2 medical technology by creating another hurdle to  
3 reimbursement. However, I would argue by itself cost-  
4 effectiveness analysis doesn't necessarily impede  
5 innovation. Innovation depends on many factors, including  
6 systemwide incentives, society's overall willingness to  
7 spend money for health, and how firmly a cost-effectiveness  
8 threshold is applied. The use of cost-effectiveness  
9 analysis, as Dr. Eddy argued, could even stimulate  
10 manufacturers to bring more cost-effective products to the  
11 market in the first place.

12           Moreover, the absence of cost-effectiveness  
13 analysis does not necessarily translate into an innovation-  
14 friendly environment. It simply means that payers find  
15 other less obvious, and sometimes less honest ways, to  
16 ration care, by cutting payments, for example, and  
17 restricting access in other ways.

18           Application of cost-effectiveness analysis for  
19 Medicare Vatacan will likely require an ongoing campaign to  
20 educate policymakers and the public, require outreach to an  
21 array of stakeholders. In theory, CMS could simply grant  
22 itself the authority to use cost-effectiveness analysis with

1 a broad interpretation of its statutory language to cover  
2 reasonable and necessary services.

3           Alternatively, CMS could pursue such an action in  
4 formal rulemaking, though to date both of these channels  
5 have proven impossible. Another avenue would involve  
6 congressional action. Congress could legislate, for  
7 example, the criteria, including cost-effectiveness  
8 analysis, that Medicare should use in covering new  
9 technologies. When adding new health benefits to the  
10 Medicare program, Congress could mandate that CMS determine  
11 the most cost-effective ways for doing so, for example.

12           In closing, let me emphasize that whether a  
13 medical technology or any strategy offers good value is a  
14 question that can best be informed by a careful analysis. I  
15 would encourage the judicious use of cost-effectiveness  
16 analysis by Medicare in the years ahead.

17           Thank you very much. I look forward to your  
18 questions.

19           MR. HACKBARTH: Thanks to both of you. One of the  
20 Commission's interests is pay for performance, and we're  
21 eager to move the Medicare program and the health care  
22 system in general towards paying more for better

1 performance. Each of you alluded to the potential use of  
2 cost-effectiveness analysis in guideline development. Could  
3 I ask you both to say a little bit more about that? To what  
4 extent is it currently used? Are there differences in  
5 practices? And if we chose to go that route of urging the  
6 use of cost-effectiveness analysis in guideline development,  
7 how might we go about doing that?

8 DR. EDDY: I'm sorry, your question started off  
9 talking about pay for performance, but you'd like me to  
10 answer it in terms of the use of cost-effectiveness analysis  
11 for guidelines?

12 MR. HACKBARTH: Let me be explicit about the link  
13 that I see. One type of pay for performance is paying  
14 explicitly for certain things being done based on clinical  
15 guidelines. That raises the question in my mind of whether  
16 the guideline itself has been developed using cost-  
17 effectiveness analysis, which I think is one of the issues  
18 that you used. That's a door that you could enter this  
19 process through.

20 DR. EDDY: Yes, I can give you some examples. I  
21 can't tell you how pervasive this is. That is, the extent  
22 to which it's use, because I can only see the guideline

1 world through my eyes. But I can go back to 1980 when the  
2 American Cancer Society wrote hugely important national  
3 guidelines for cancer screening -- front page of the New  
4 York Times -- and there was cost-effectiveness analysis all  
5 through it. I don't think people realized it but it was all  
6 through it.

7           It recommended, for example, three-year Pap smears  
8 instead of annual Pap smears, and the logic was that you get  
9 98-plus percent of the benefit with a three-year Pap smear  
10 compared to an annual Pap smear and the extra money was much  
11 better put into making sure that everyone gets at least a  
12 three-year Pap smear. Probably most of us in this room are  
13 candidates for colonoscopies, and something like that,  
14 that's recommended every five to 10 years. Don't tell me  
15 that an annual colonoscopy wouldn't provide a little bit  
16 more benefit. It's just not cost-effectiveness, in a sense.

17           So there a fair number of examples like that where  
18 cost-effectiveness analysis certainly, I think, contributed  
19 to a recommendation that makes a trade-off between the  
20 amount of quality you're getting and the amount of cost  
21 you're paying.

22           Can I make a comment quickly about pay for

1 performance?

2 MR. HACKBARTH: Before you do that, the inference  
3 I was drawing, and maybe incorrectly, from what you said  
4 earlier in your presentation was cost-effectiveness analysis  
5 is used sometimes, but not always, or perhaps  
6 inconsistently, in guideline development. Did I understand  
7 you correctly?

8 DR. EDDY: That is absolutely correct.

9 MR. HACKBARTH: So you cited an example of where  
10 it was at least implicitly applied. Is that the usual  
11 thing?

12 DR. EDDY: No.

13 MR. HACKBARTH: And how do people -- that's what  
14 I'm trying understand better.

15 DR. EDDY: I don't think so. Again, I don't know  
16 of a survey but I would strongly suspect that cost-  
17 effectiveness analysis would -- I'm talking about real  
18 guidelines that are actually issued by organizations and  
19 really changes things as opposed to papers that we might  
20 write that may or may not change things.

21 I'm sorry, I've just drawn a blank. Ask me the  
22 question again. Just give me the key word.

1           MR. HACKBARTH: So how common is it that cost-  
2 effectiveness analysis --

3           DR. EDDY: Not very common. You very frequently  
4 see national guidelines that, for example, push the target  
5 for cholesterol treatment down to lower and lower levels and  
6 there's no explicit cost-effectiveness analysis behind that.  
7 Try as hard as we can to put cost-effectiveness analysis  
8 into performance measures, it's just been very difficult to  
9 do that. There are some examples where it's been done, but  
10 there are a lot of examples where it hasn't been done and  
11 there's no explicit cost-effectiveness analysis behind it.  
12 My guess would be -- this is a guess -- 10, 20 percent of  
13 guidelines would have some element of an explicit cost-  
14 effectiveness analysis behind it.

15           MR. HACKBARTH: Then the other piece related to  
16 that was, again, we're eager to see Medicare pushed down the  
17 path of saying there should be more guidelines, and payment  
18 link in some cases to those guidelines. What are the  
19 levers, if we want to see guidelines that incorporate cost-  
20 effectiveness analysis, what are the levers that you try to  
21 pull to change the guideline development process? Any  
22 thoughts about that?

1 DR. EDDY: That would be fairly straightforward.  
2 You can add a requirement, if you will, that there be a  
3 cost-effectiveness analysis behind it as well.

4 DR. NEUMANN: I guess I would add a few things. I  
5 would start by agreeing with Dr. Eddy, it does seem like  
6 clinical guidelines, published guidelines, typically do not  
7 use or even cite cost-effectiveness analyses. There was a  
8 paper a couple years ago that looked at hundreds of  
9 guidelines simply to look at whether anywhere in the  
10 clinical guideline there was a mention or a citation to a  
11 cost-effectiveness analysis, and the vast majority did not  
12 even have such a citation.

13 There are a few exceptions. The cholesterol  
14 guidelines, at least in the old days, would cite some of the  
15 published cost-effectiveness studies, although as Dr. Eddy  
16 mentioned, some of the more recent cholesterol guidelines  
17 seem to be pushing beyond what most people would consider  
18 cost-effectiveness. The U.S. Preventive Services Task Force  
19 has discussed this very actively over the years. In its  
20 latest edition, at least at the outset said it would in fact  
21 use cost-effectiveness analysis or appeal to such analyses  
22 in helping to inform its decisions, although as the

1 guidelines have come and been published over the last few  
2 years, it doesn't seem as though they're actually using  
3 cost-effectiveness analysis.

4 I'd agree with Dr. Eddy, you could simply try to  
5 require that guidelines appeal to cost-effectiveness  
6 information. You could also, and this perhaps gets more to  
7 the pay for performance question, you could try to encourage  
8 or perhaps require that decision-makers use cost-  
9 effectiveness analysis.

10 Formulary committees is one example, and maybe  
11 this is something you just put information out there and let  
12 the private decision-makers make those decisions for the  
13 Medicare beneficiaries. But it could be that a cost-  
14 effectiveness analysis informs the formulary decision. It  
15 could be a high-priced drug actually is better as first-line  
16 treatment because it's cost-effective in a larger sense.  
17 And conversely, it could be that a low-priced drug is not  
18 cost-effective because it's not going to give good value.

19 MS. BURKE: I wonder if I could ask a fairly  
20 simplistic question? That is -- really twofold. One, on  
21 average, what would it cost to do a cost-effectiveness  
22 study? And what period of time is normally required for one



1 to occur?

2           Secondly, currently, to what extent is information  
3 available on the breadth of things that Medicare currently  
4 covers?

5           For example, if we were to say that all coverage  
6 decisions ought to in fact take into consideration cost-  
7 effectiveness going forward, but also retrospectively, the  
8 things that we currently do, if we wanted to validate as we  
9 move towards pay for performance and look at the validity of  
10 the things that we currently do, to what extent could we in  
11 fact do that with current studies? That is, to what extent  
12 are all the range of things that Medicare currently does, is  
13 there information available that would allow us to do those  
14 studies today?

15           DR. NEUMANN: Starting with how much it would cost  
16 and how much time it would take. Certainly, evidence costs  
17 money and cost-effectiveness analyses require resources and  
18 time, and in some sense I suppose you get what you pay for.  
19 I think the experience in the U.K. with NIC perhaps is a  
20 good example. It probably varies by technology and  
21 complexity, but my sense is they are contracting out those  
22 studies and I would give a rough ballpark, on average it

1 takes a few months and \$50,000. Sometimes you can probably  
2 do some quick, dirty, back of the envelope calculations.  
3 Sometimes you probably, given uncertainty and what's at  
4 stake, want to collect primary data and take longer and  
5 costs a lot more than that.

6 As far as your second question, how much  
7 information is currently available. I guess I would say  
8 there's a fair amount of cost-effectiveness analysis out  
9 there. My colleagues and I have been collecting this and  
10 putting it into a database and hundreds, thousands of  
11 studies. Not all of them of high quality, but a fair amount  
12 to inform decisions.

13 Having said there, they're clearly are information  
14 gaps. I think part of this whole discussion probably needs  
15 to talk about those information gaps, and who puts  
16 information out there for decision-makers. Any attempt to  
17 use cost-effectiveness analysis will require some  
18 prioritization, and you might well want to start with big  
19 ticket items, expensive technologies, and probably requires  
20 some additional analyses.

21 MS. BURKE: I was quite struck at the closure of  
22 your remarks, Dr. Eddy, the sense that there may be other

1 ways to start, or other places to start rather than just  
2 right at the coverage point, but that we may be informed.  
3 One of the things that occurs to me, Glenn, as we look at  
4 this issue and look at how one might begin to incorporate  
5 this information, is the extent to which we move towards pay  
6 the performance, is the extent to which we move towards  
7 other decision points.

8           The reason I asked the question is, how realistic  
9 is it? Given all of the other things that occur -- Nancy-  
10 Ann has probably got the best sense of how much of that  
11 could currently be taken into consideration. But it would  
12 seem to me from the Commission's standpoint that some  
13 attempt at understanding and suggesting some order of  
14 priority and some areas of intervention, whether it's in pay  
15 for performance or others, might well be something we ought  
16 to consider and think about, taking into consideration the  
17 amount of information currently available, whether you start  
18 with the highest priority items, the big-ticket items, the  
19 ones that are the most frequency, or the ones around which  
20 there is the greatest question as to its current relevancy  
21 in terms of current practice. Might make some sense to give  
22 some thought to that in further conversation.

1 DR. EDDY: I agree with Peter generally about the  
2 cost and the time; it varies a lot. \$50,000, in my  
3 experience, would be at the lower end. It can go to  
4 \$100,000, \$150,000 or something like that.

5 In terms of your second question about how much  
6 work has already been done that we can simply draw on, a lot  
7 of work has been done but I'm nervous about drawing on it.  
8 The main reason is that whenever you do a cost-effectiveness  
9 analysis there is a very specific population, a very  
10 specific intervention, very specific outcomes that are in  
11 mind, and we might think that we --

12 For example, have done a cost-effectiveness  
13 analysis -- just to pick a recent example in the Annals of  
14 Internal Medicine of "diabetes prevention." Whether you're  
15 talking about people who don't yet have diabetes, or they've  
16 got impaired fasting glucose and impaired glucose tolerance,  
17 or just impaired glucose tolerance, or impaired glucose  
18 tolerance plus their BMI is over 25, and whether we're  
19 talking about a group-delivered method for getting them to  
20 lose weight, or a personal physician-based, you can throw  
21 that cost-effectiveness all over the place. So although a  
22 good analysis has been done -- let's assume it's a good

1 analysis -- it's of a very specific population with a very  
2 specific intervention, and you'll get a totally different  
3 answer simply by redefining the problem.

4           So now let me go to your third point, which is  
5 whether something like pay for performance might be a place  
6 to start. I, indeed, think it would be, because pay for  
7 performance is a guideline with real teeth, I mean real  
8 teeth in it, and there's a finite number of these measures  
9 that are being considered for pay for performance. I think  
10 it's on the order of a couple score maybe to 100 or  
11 something like that. It is feasible to, I think, do  
12 analyses of those. And because it's pay for performance  
13 you'll have very specific definitions of the populations,  
14 the numerator, the denominator, and you can really do an  
15 analysis. And it will be done right, and it will be from  
16 the start, if you will, an agreed-on set of methods that I  
17 think you can really trust do in fact address the problem  
18 that you're asking.

19           So I think it would be very difficult to go back  
20 and get things. You might well want to do that for selected  
21 cases where you have something that you really suspect is  
22 eating you alive financially and you want to do a cost-

1 effectiveness analysis. That would make sense. But to try  
2 to do something across the board I think would be difficult.  
3 But I would strongly propose that you do it going forward  
4 and like Quicken, when you buy Quicken you've got to decide  
5 whether you're going to hand enter all your transactions  
6 from the past 15 years or you're just going to enter them  
7 from that year forward. At least let's make sure that we're  
8 doing it from this point on, and in a couple of years we'll  
9 be in pretty good shape.

10 MS. DePARLE: I wanted to go back to Dr. Eddy's  
11 slide about what will CMS need to pull this off. I don't  
12 know if you can put it back up there easily, Dr. Eddy, but  
13 you listed four things, I guess starting off with criteria  
14 for deciding whether a model is sufficiently valid and  
15 accurate to be used to estimate health outcomes. I think I  
16 would add several other things. So in addition to criteria,  
17 I think there are a host of other things CMS would need, in  
18 my experience. A lot of courage, and congressional support,  
19 among other things, would be important. I think, Peter, you  
20 alluded to that as well.

21 But it looking at this list here -- and by the  
22 way, Peter, you talked some about whether or not CMS could

1 just do this through its reasonable and necessary authority.  
2 Legally, you're probably right. They probably could. But I  
3 think it's a big enough change and an important enough  
4 change that it should be something that -- again, maybe I  
5 have an overly idealistic view of government, but it should  
6 be something that we discuss explicitly, and people agree on  
7 and understand.

8           By the way, I think, notwithstanding, what you  
9 said, Dr. Eddy, about at least doing it going forward, I  
10 agree with that, although I do think sometimes we hold new  
11 technologies and new things to a higher standard than the  
12 old stuff. When you look at how many millions of dollars  
13 Medicare is spending every second that we sit here, much of  
14 it on stuff that doesn't work, then I have a bit of a  
15 problem with just saying, let's do it going forward.

16           But if we were ever to get to a point where we  
17 could institutionalize something almost like an  
18 environmental impact statement that you would always do  
19 about whatever procedure or intervention you have, it seems  
20 to me we need these things that you've listed here, and I  
21 don't think CMS can come up with those on its own.

22           So what would ask the two of you is, given what

1 you said, Dr. Eddy, about the state of the art of cost-  
2 effectiveness analysis, is there a group of people who are  
3 experts in this, along with beneficiary representatives and  
4 stakeholders from the medical device industry and  
5 clinicians, who could sit in a room for a year in a  
6 negotiated rulemaking and come up with something that we  
7 could use as a standard so that we could do this routinely?  
8 If that were the case, then spending \$50,000 on a study,  
9 frankly, is nothing compared to what we're spending every  
10 day, so I think people could support it.

11 But without that, I don't see how Congress is  
12 going to get behind something like this, and therefore, I  
13 don't see how the agency can really move forward. We could  
14 do it in payment, and I think both of you said we're doing  
15 it right sub rosa, just by local coverage decisions and  
16 LMRPs and those sorts of things, and payment policy. But I  
17 would prefer, if this is the right way to go, and I'm  
18 convinced it probably is, we do explicitly. Let's all agree  
19 this is what we're going to do.

20 There's a lot imbedded in that, but could people  
21 get together and come up with something that everyone could  
22 agree is legitimate and a good way to assess new



1 technologies?

2 DR. EDDY: Sure, I do believe that. For one  
3 thing, Peter is the upcoming president of ISPOR,  
4 International Society for Pharmacy Outcomes Research and  
5 they've already got a paper on methodology for the cost-  
6 effectiveness analysis, and if it's expanded a little bit I  
7 think that could do it.

8 If you want something that might be considered by  
9 some to be more impartial because it's not just  
10 pharmacoeconomic research and so forth, an organizations  
11 like NCQA could do it. I can image the Quality Forum doing  
12 it. So, yes, there are lots of groups that could take the  
13 leadership. I personally would favor NCQA, but that's just  
14 a preference that I've got, because they've played that role  
15 in several other things. But in many fields we see  
16 successful attempts to standardize approaches to  
17 extraordinarily complex problems, such as information  
18 systems, for example, and the standardization of information  
19 transfer. So that certainly can be done.

20 I also agree with you, and I might not have  
21 emphasized it quite as much, that if we do -- my answer to  
22 Sheila Burke's question was I don't think we can do an

1 across-the-board analysis of all the old technologies from  
2 existing cost-effectiveness analyses. But by all means, if  
3 there is some particular technologies out there, I think I  
4 used the term are eating you alive. Perhaps it's too  
5 informal. But in any event, that are very expensive and so  
6 forth, I think it would make very good sense to go and look  
7 at those.

8 I think I'll stop there. I have some other  
9 thoughts about how to do that in a process way but I don't  
10 think it would be important to go into that now.

11 DR. NEUMANN: I'd just add a few things. I agree  
12 with you, legally Medicare probably could do it or do it  
13 through rulemaking. I think practically, it's proven  
14 impossible and it needs, if not congressional action, which  
15 maybe is what it needs, it needs certainly a lot more buy-in  
16 from a lot more stakeholders.

17 As far as whether we could do it, I would agree,  
18 not only can we, but there is experience, again, in the U.K.  
19 and elsewhere in Europe, in Canada, Australia, decision-  
20 makers have done it. They've gotten people together. It  
21 hasn't always been easy. There have been challenges.  
22 There's been resistance. And undoubtedly there would be all

1 of those things for the U.S., but it has been done. People  
2 have agreed upon rules and they have gone forward using this  
3 technique.

4 DR. REISCHAUER: I'd like to thank you for two  
5 really excellent presentations. They were both clear and  
6 very informative. Of course, when one thinks you know  
7 something about it and then the real experts come, you  
8 realize how inadequate your understanding is. I have a  
9 million questions but I will just raise a few.

10 One has to do with Dr. Eddy's feeling that we  
11 should test the models against the real world. I always  
12 thought my profession, economics, had a tough time with  
13 models but we have a lot of data from the real world. And  
14 one thinks about this area, and when we're talking about  
15 something old that's been around for a long time I can see  
16 it. But a lot of what is being done has to do with new  
17 procedures, new devices, new pharmaceuticals where the costs  
18 over time should change radically, decline often.

19 In the simplistic example, this would be a  
20 pharmaceutical coming off patent. While lowering  
21 cholesterol might be cost ineffective at the price of  
22 Lipitor now, Lipitor in a generic form might change the

1 equation radically. And then you think about effectiveness,  
2 and presumably there's some learning by doing, and  
3 effectiveness could improve over time. And how you go about  
4 modeling that. If you say, provisionally we go ahead with  
5 this stuff at one threshold of cost-effectiveness, assuming  
6 costs are going to fall and effectiveness is going to rise,  
7 by the time you have the information to do the hard-nosed  
8 analysis from the real world data you have an interest group  
9 with offices on K Street, you have the whole profession  
10 providing this service and not wanting to do it, so it  
11 becomes a takeaway, which makes it a lot more complicated  
12 from a political standpoint.

13           The other observation I'd make is that it strikes  
14 me just from the news that's come out over the last few  
15 years that true cost-effectiveness depends very much also on  
16 the secondary effects, which you don't pick up until many  
17 years later when you have huge masses of data from large  
18 populations and you find that this procedure that you did on  
19 the knee or whatever turns out to cause strokes in people  
20 who also are taking vitamin E or something like that, and  
21 suddenly -- or eating pork chops, something that is a  
22 normal, standard behavior of most people, and suddenly it

1 becomes terribly ineffective, and what do you do about that?

2 DR. EDDY: Those are all very good points and they  
3 are, by and large, very real limitations to cost-  
4 effectiveness analysis that we can try to understand, but  
5 almost by definition we can't really get rid of. Let's  
6 start with the evidence. First of all, for any new  
7 technology very often there is no randomized, controlled  
8 trial or something like that sitting right on top of it. Or  
9 if there is a randomized, controlled trial you're going to  
10 use the randomized, controlled trial and it will drive the  
11 analysis, so a lot of the modeling questions begin to  
12 disappear.

13 My proposal for anchoring a model to existing  
14 trials would be applied to new technologies in the following  
15 way. I would ask that if the model is going to be asked a  
16 question that has not yet been studied in a clinical trial I  
17 want to see that the model has accurately predicted what  
18 I'll call adjacent clinical trials, trials in similar  
19 populations involving the same kind of organ system and  
20 outcomes, involving similar treatments and so forth. So I  
21 would propose that that's a way of gaining confidence that a  
22 model can handle a problem that has not yet been addressed

1 in a trial.

2           Now let's talk about the problem that everything  
3 is changing out from under you. The costs are changing, the  
4 effectiveness can change. That is also absolutely true.  
5 But that's where sensitivity analysis, I think is really  
6 helpful. If you're sure that your basic model is correct  
7 then you can begin to play with assumptions about whether  
8 the cost of a drug, for example, drops to a generic cost or  
9 something like that.

10           For the effectiveness, a good model can handle the  
11 human behavior parts of what happens in reality. That is,  
12 it can capture that. And if one really wanted to go to an  
13 extreme, although it's not very expensive -- it costs tens  
14 of thousands of dollars -- you could do a little pilot study  
15 that gave you a sense of how, for example, the  
16 implementation of a treatment in a real setting might differ  
17 from the implementation of a treatment in a clinical trial  
18 or something like that where you're getting your baseline  
19 assumptions.

20           So if you believe the basic model, then good will  
21 have the ability to address those and give you a sense of  
22 how important they are.

1           Then in terms of the secondary effects, by  
2 definition a model or an expert or anyone else can't see it.  
3 By definition it's invisible until you get an enormous data  
4 set, and we only can guess how many are out there which  
5 remain invisible because it takes too many people and too  
6 big a data set to ever find them. What a model can do is  
7 take that information into account once it's discovered.  
8 But I'm not going to pretend that a model could have  
9 predicted the effect of Phen-Fen on mitral valves. It would  
10 have, by the way, found the effect of Vioxx on coronary  
11 artery disease because there was information out there that  
12 a good modeling group would know about and would incorporate  
13 in their model. So it can handle some of that but it's not  
14 going to find the totally unexpected things.

15           Finally I'll say, all the things you've mentioned  
16 are very real and they're limitations for models, but  
17 they're also limitations to any other method you use that  
18 doesn't address cost-effectiveness analysis. For example,  
19 it's not as though expert judgment, or I don't know what,  
20 common practice patterns or something like that are going to  
21 solve any of these problems. They're all very real problems  
22 that just have to be considered.

1 DR. NEUMANN: I guess I would just emphasize that  
2 last point. You identify many important problems, changes  
3 over time and so forth. My experience has been, discussions  
4 of cost-effectiveness often focus on its limitations, its  
5 methodological problems and so forth, and there's almost a  
6 temptation to throw up our hands. But the real question is,  
7 and the right question is whether it's better than the  
8 alternative, as Dr. Eddy said. And cost-effectiveness  
9 analysis, in addition to identifying the costs, at least  
10 probable costs, and benefits can also often help us identify  
11 uncertainty and characterize uncertainty, and help us think  
12 about the costs and benefits of collecting additional  
13 information.

14 I guess the final thing is, groups like NIC in the  
15 U.K. often revisit decisions over time. They just, last  
16 week, revisited their decision on Alzheimer's disease from  
17 2001, for example, in light of new information that's become  
18 available. That undoubtedly would be something to consider  
19 in the future.

20 DR. MILSTEIN: Given that we wouldn't be  
21 trailblazers if we went down this path, that we the U.K. and  
22 Australia ahead of us in this activity, I wanted to ask if



1 you both would be willing to run a spontaneous model in your  
2 minds and respond to the following request for a  
3 guesstimate. If tomorrow the Medicare program were to put  
4 the available stockpile of credible cost-effectiveness  
5 studies, maybe drawing on NIC and others that would pass  
6 your minimum test for methodological robustness, if the  
7 Medicare program tomorrow were to put that evidence to work  
8 in one or other of the following two ways, order of  
9 magnitude, what difference would it make do you think in  
10 terms of percentage point reduction in per capita Medicare  
11 spending trend? Let me tell you the two. I realize  
12 according to Malcolm Gladwell it's fair for me to ask you  
13 this because you're the experts.

14 First, what if essentially Medicare were to apply  
15 the same thresholds that are being applied in the U.K., how  
16 much would that meaningfully impact Medicare? How many  
17 percentage points, if any, would that meaningfully impact  
18 Medicare spending trend?

19 Then let me ask you to model a less extreme  
20 application, and that would be, if Medicare simply made as a  
21 condition of coverage something analogous to step therapy  
22 where if there were two treatments that had -- both likely

1 to have a favorable outcome for a patient with a given  
2 condition, what if the Medicare coverage required that the  
3 more cost-effective treatment option be tried first before  
4 the less cost-effective options were applied? Order of  
5 magnitude, would that be a tenth of a percentage point, 10  
6 percentage points? I'm trying to get a sense of how  
7 potentially beneficial this therapy might be with respect to  
8 meaningfully impacting Medicare cost trend.

9 DR. NEUMANN: A couple of things. Of course it  
10 will depend on how one applies the cost-effectiveness  
11 analysis and what threshold is used.

12 DR. MILSTEIN: That's why I suggested for the  
13 first question we use whatever the U.K. --

14 DR. NEUMANN: The U.K. has been using a threshold  
15 of roughly 30,000 pounds, now it looks like 20,000 pounds,  
16 which by U.S. standards seems to be low. Even in the U.K.  
17 it seems that overall spending is not necessarily decreasing  
18 over time despite application of that threshold, and the  
19 reason is there's many other things going on in their  
20 system, and they're changing incentives, putting more money  
21 into the system, and so forth. So part of my answer would  
22 be it also depends on those things in our country. In fact

1 it probably depends largely on those things.

2 My guess is total impact on health spending would  
3 be rather minimal, for a couple of reasons. We're getting  
4 new technologies that are worthwhile and probably offer good  
5 value, we're aging, and all the rest. There would be a lot  
6 of pressure to use those technologies, and even to use cost-  
7 effectiveness analysis to argue for more spending for many  
8 technologies.

9 So I hate to put a number on it, but I think it  
10 would be 1 percent lower maybe. And a lot will depend on  
11 political will on how you would use it. You certainly could  
12 use it to do much more much more of a strong tool to contain  
13 costs. That hasn't been the experience of payers who have  
14 use it.

15 DR. REISCHAUER: Your 1 percent was a level  
16 adjustment or a change in the rate of growth?

17 DR. NEUMANN: I guess I was thinking change in  
18 rate of growth.

19 DR. REISCHAUER: Whoa.

20 DR. NEUMANN: You think that's big. I did say  
21 less than 1 percent.

22 DR. REISCHAUER: You got our attention.

1 DR. MILSTEIN: Do you want to take on the step  
2 therapy question?

3 DR. NEUMANN: What was the precise question?

4 DR. MILSTEIN: Instead of using simply using it as  
5 a cut-off, a less severe approach would be to simply say,  
6 when there are multiple therapeutic options that would be  
7 reasonable for a patient for the same condition, that the  
8 Medicare coverage rules require that the more cost-effective  
9 option be tried before going to the less cost-effective  
10 option. I take it it would be something south of one  
11 percentage point.

12 DR. NEUMANN: Right. Again, probably minimal  
13 impact of spending. The other part of this whole thing is  
14 how much you require and how much the government puts out  
15 information and does analyses for the private plans, Part D  
16 plans, for example, to use the cost-effective information to  
17 enact their own policies. So for example, AHRQ, someone  
18 might do the analyses, put it out there, and let the plans  
19 use it to inform formulary policies, step therapy, tiered  
20 copays, prior authorization, preferred privilege, whatever.

21 DR. EDDY: Having had a little bit more time to  
22 collect my thoughts, first I'll just repeat but perhaps

1 stress even more the importance of the threshold.

2 Obviously, that's absolutely critical, and I had to say I'm  
3 very nervous about a threshold in the range of \$50,000, for  
4 example. If you take to account the fact that the gross  
5 total family income in the United States is on the order of  
6 \$45,000, perhaps \$50,000 and that's covering three and-a-  
7 half people. We don't have that much money per person.

8           Now I understand that we're talking about average  
9 versus marginal cost-effectiveness and so forth, but I just  
10 think that someone really needs to think very carefully  
11 about that number. If any of you know the history of how we  
12 come to various thresholds you'll appreciate that it's not  
13 the result of a really rigorous analysis with true agreement  
14 by "society" about what the threshold ought to be. So I  
15 think costs might well go up if we had a threshold of, for  
16 example, \$50,000 or 40,000 pounds.

17           MR. HACKBARTH: Could I just ask for a  
18 clarification on that? I thought Peter said the NIC  
19 threshold was 20,000 pounds, which isn't too far from what  
20 you're talking about, \$50,000.

21           DR. EDDY: That's right. That's why I picked that  
22 number. Actually what Peter said, it's 20,000 to 30,000.

1 It's at 30,000 now going down to 20,000. So with the  
2 exchange rate at 1.93278 --

3 MR. HACKBARTH: So you're saying that that sounds  
4 like I a high number to you relative to incomes.

5 DR. EDDY: It sounds high; absolutely. I just  
6 know that, for example, if we all had a disease that caused  
7 us to die on January 1st and there was a pill that we could  
8 take to keep us this alive until December 31st, we could not  
9 begin to afford it if we spent the entire gross domestic  
10 product on that pill.

11 Now understand, a good economist here knows  
12 exactly the trick that I just played on you. But the fact  
13 is I think we need to think much more carefully about what  
14 the threshold ought to be than we have so far. That's not  
15 to disparage the thinking that's gone into it, it is just  
16 there are lots of different constituencies, if you will,  
17 that are pulling and pushing this threshold because that is  
18 of huge importance. I think that is one of the things. I  
19 think I've got it on my list, don't I? Yes, it's the last  
20 bullet there. You really have to pay a lot of attention to  
21 that. I don't think that that the problem is solved.

22 Now having said that, to try to answer your

1 question, Arnie, I'm trying to guess -- this is a guess and  
2 everyone understands that, and there's no one that's going  
3 to write this in some pink sheet sitting behind me, right?  
4 I'm just trying to guess what proportion -- I'm trying to  
5 think of how many -- the extent of under-use of cost -- let  
6 me go back to a point Peter raised. Cost-effectiveness does  
7 not mean cost-saving. You can spend money --

8 All right, so the question is, to what extent are  
9 we under-utilizing cost-effective things, so we'd use more  
10 of it, as opposed to we're over-using cost-ineffective  
11 things, which means if we could apply this technology or the  
12 methodology we should be saving money? I tend to think that  
13 the forces that are at work from patients, from physicians,  
14 from pharmaceutical companies, from newspapers, from the  
15 courts tend to push more towards the over-use of things that  
16 will turn out to be cost-ineffective than the under-use of  
17 things that are cost-effective. So I think you would  
18 probably see a decrease.

19 But there are lots of caveats wrapped around that,  
20 and the biggest one is going to be that there's an under --  
21 some of the things that are under-used now that we strongly  
22 suspect will be cost-effective, can affect a huge proportion

1 of the population. They are some of the preventive  
2 activities for things like coronary artery disease where  
3 almost every adult can end up taking -- and if you, for  
4 example, aren't very careful in terms of which drug is  
5 recommended and how much you pay for that drug and so forth,  
6 that can have an enormous effect on the answer to that  
7 question.

8 DR. NELSON: I want to take something that Arnie  
9 started with you, a bit further and ask how you would apply  
10 better cost-effective analysis to the development of  
11 formularies under Part D. The cost estimates are enormously  
12 variable and probably understated, and the folks who will be  
13 developing the formulary, understanding that a good bit of  
14 the therapeutic category bands have already gelled and  
15 they're fairly narrow and may not provide as much  
16 opportunity for cost-effective theory to be applied as would  
17 otherwise be the case. Nonetheless, it seems to me that the  
18 enormous marketing clout of the industry is going to be a  
19 challenge for the formulary committees and that solid cost-  
20 effectiveness information around a half dozen different  
21 categories of drugs, statins, anti-hypertensive, oral agents  
22 for metabolic syndrome, outpatient antibiotics, for example,



1 would be enormously helpful in guiding rational decisions as  
2 those formularies are constructed.

3           So my question is where you see the opportunities  
4 for assisting in those rational decisions and how MedPAC  
5 might assist that process to go forward.

6           DR. EDDY: I do think it's possible to identify  
7 some particularly important formulary decisions. By  
8 particularly important I mean they affect large proportions  
9 of the population and there are a variety of ways that, for  
10 example, the treatments can be given that could swing costs  
11 a lot. I do think it would be possible -- so there is a  
12 finite number of these things. We might identify a dozen  
13 that are particularly important, which means that I think  
14 it's quite feasible to do.

15           If I might go back to a point that Ms. DeParle  
16 raised, \$100,000, \$200,000 is a lot of money to someone  
17 doing an analysis but it's peanuts compared to the amount of  
18 money that goes into this. You're talking billions of  
19 dollars, and a cost-effectiveness analysis could really have  
20 enormous leverage in terms of helping make sense out of  
21 those costs. So I think there's a good opportunity there.

22           DR. NEUMANN: I'd agree, and conceptually it makes

1 sense. It, in theory, will move us off and move formulary  
2 committees off simply looking at prices and rebates and so  
3 forth into a better discussion about overall value and  
4 health and so forth. In practice, there will be challenges  
5 as we discussed, but I would agree with Dr. Eddy that we can  
6 prioritize, probably find some areas where it can be very  
7 important, some big-ticket items.

8           The other area I'd just go back to is an  
9 information problem. There is this provision in the  
10 Medicare Modernization Act, Section 1013, that talks about  
11 comparative effectiveness, not cost-effectiveness. But the  
12 idea is we may need more information to put out to the  
13 formulary committees and have them try to construct value-  
14 based formularies, given some of the constraints you  
15 mentioned around therapeutic class and so forth. But there  
16 does seem to be a need for more and better information and  
17 that is a role that I think could be discussed and a role  
18 that the government could play.

19           DR. NELSON: Providing the information is  
20 certainly an important first step, but there may be some  
21 leverage beyond that that can properly be applied to assure  
22 that some of these factors are considered as they make their

1 decisions. We're talking about pay for performance across a  
2 whole range of services within Medicare. I'd like to think  
3 of ways that incentives can be provided for committees to  
4 assist their decision-making, apart from just having the  
5 information available, which is going to be arrayed, again  
6 as I said, against the tens of billions of dollars that the  
7 industry has used in marketing, including direct to consumer  
8 advertising.

9 DR. NEUMANN: I'd agree, information itself won't  
10 solve the problem and will only go so far. Even with  
11 information put out to formulary committees, Medicare still  
12 has its Part B drugs and technologies, its national coverage  
13 decisions. I talked in my remarks about the fact that when  
14 Congress adds new benefits, as it did with MMA, various  
15 screening benefits, for example, it might either use cost-  
16 effectiveness analysis to determine which benefits should be  
17 added or provide some language that CMS should use cost-  
18 effectiveness analysis in terms of deciding which particular  
19 strategy under the general heading of a new screening  
20 procedure should be used.

21 But I agree with you also that incentives are a  
22 big part of this and anything we do in cost-effectiveness

1 should be accompanied by serious consideration of changing  
2 incentives.

3 DR. CROSSON: I actually have a question for Peter  
4 although, David, you may want to comment too. It has to do  
5 with the point you made about the fact that in other  
6 industrialized countries cost-effectiveness analysis seems  
7 to be more common at the moment than it is in the United  
8 States. The question really is about the underlying -- it  
9 guess it was one of the unspoken issues here -- is the  
10 underlying cultural issues or underlying cultural values,  
11 because I think -- I understand there are payer differences  
12 and at least when people tend to talk about this we hear  
13 things like this works in England or it works in Europe but  
14 it won't work in the United States because we have a  
15 different set of cultural values. I'm not sure whether  
16 that's the case or not but people believe that.

17 For example, David, in the paper we read, your  
18 conversation, your conversation with your father, you talked  
19 about the fact that cost-effectiveness analysis is  
20 predicated on the idea that resources are limited, and  
21 without that predicate it makes no sense. So I guess there  
22 are questions about whether we actually, in this country,

1 believe resources are limited or whether some people believe  
2 resources are limited for some but not everybody.

3           There's the question of whether there's a common  
4 good and whether that common good should have any influence  
5 at all over choices that are available to individuals. I  
6 think, at least to me these are some of the underlying  
7 issues that then are reflected in some of the political  
8 obstacles that we've talked about.

9           So my question is this, from an international  
10 perspective, do you believe from your observations that  
11 there is such a difference? Then the second part of the  
12 question is, is this a static thing or is it dynamic? From  
13 the perspective of other industrialized countries, do you  
14 see in fact cultural values changing as more information is  
15 made available, there's a public discourse about issues like  
16 this? Is in fact this a static difference or is it  
17 something that can and could be influenced over time in this  
18 country with a dialogue about values and things of that  
19 kind?

20           DR. NEUMANN: I think you put your finger on the  
21 heart a lot of what underlies this discussion. I do believe  
22 there is a difference, cultural, political, values, and in

1 fact it is striking when you talk to people and read about  
2 what's done in England and elsewhere and Europe, even in  
3 Canada, Australia. They will not cover a new drug or  
4 technology because it is too expensive given the health  
5 gains, even though there's agreement that there's some  
6 positive health benefit, in ways that have never been  
7 acceptable here. And why not acceptable here? You  
8 mentioned perceptions, beliefs that resources really aren't  
9 limited, a sense of entitlement about these funds, and you  
10 can't explicitly ration, and so forth. So I think that  
11 seems to be the case for reasons that we probably could  
12 spend a lot of time on, historical and so forth.

13           Whether this is dynamic or static, my best sense  
14 is this is very much dynamic. There is a view that all of  
15 these countries went through their own long-term social  
16 changes and got to a place where they can use it, even  
17 though they started, perhaps, in different place. We're  
18 probably on a different trajectory. Undoubtedly we are.  
19 But my sense is that over time we'll get ourselves there.  
20 And maybe it takes awhile, and it maybe falls short of what  
21 they're doing now, but certain things, as simply fiscal  
22 trends continue, will probably become acceptable because

1 alternatives may be worse. My sense is the conversation  
2 will change slowly and we'll see, but my sense is it will.

3 DR. EDDY: Your point about everything that we're  
4 talking about here is contingent on an assumption, if you  
5 will, that resources are limited is a very good one, and  
6 it's possible that we will decide that we actually don't  
7 have a cost cause problem, in which your report would say  
8 basically, stop complaining, to everyone. We're tired of  
9 seeing newspaper articles and fights between unions and  
10 employer groups, and complaints about rising insurance costs  
11 and the uninsured and so forth. But all the signals I get  
12 are that it's a huge problem.

13 To just, very briefly, cultural differences and so  
14 forth. I actually am very pessimistic about the prospects  
15 that our country will be able to take on explicit rationing  
16 in my lifetime, for example. It's not as though this is a  
17 new idea and we're just approaching it. It's been tried by  
18 great people for decades now and with really very little  
19 headway, I think. So I'm actually pessimistic, which is why  
20 I tend to look more for things that are much more implicit,  
21 much softer, emphasize important things, don't put sharp  
22 refusals on cost-ineffective things and so forth. Try to

1 find ways to do it that's more acceptable. But a  
2 straightforward approach to try to make rationing explicit I  
3 just think will bloody everybody.

4 MR. MULLER: I too enjoyed your presentations. A  
5 lot of what you discussed today also is available in the  
6 NCQA guidelines, NQF and so forth, has to do around drugs  
7 and medications and so forth. But a lot of the drivers of  
8 health care costs are from new surgical techniques, new  
9 diagnostic procedures, the spread of imaging, and we've  
10 taken some of those issues on, specifically imaging, at  
11 MedPAC in the past. But a lot of the work coming out of the  
12 Dartmouth group focuses on the variation that comes from  
13 that.

14 How deep is the knowledge of clinical  
15 effectiveness in those areas? Again most examples commonly  
16 -- I shouldn't say most but a lot of examples usually are  
17 around medications, but how about in those other areas,  
18 where is the body of knowledge going? Is there a lot of  
19 work being done in those areas?

20 Obviously, one could see a lot of thrust from the  
21 supplier sector there in terms of all these new  
22 interventions, imaging, et cetera, diagnostic techniques



1 driving this health care economy. So could you just comment  
2 a little bit about what's happening in those spheres?

3 DR. NEUMANN: In our database of cost-  
4 effectiveness analyses, for example, 40 percent of studies  
5 are on pharmaceuticals, which seems like a very high number  
6 given total spending on pharmaceuticals compared to total  
7 health care is maybe 10 to 12 percent. The other 60 percent  
8 are representing a wide variety of interventions, imaging,  
9 surgical procedures, education, behavioral interventions  
10 even. But in general, a disproportionate share of the  
11 attention has focused on drugs and would, in my view,  
12 probably need more attention not only on imaging and  
13 procedures but on broader disease management strategies,  
14 public health strategies, other kinds of care delivery  
15 strategies.

16 DR. MILSTEIN: Just to follow up on Ralph's point,  
17 the Dartmouth research showing a substantial variation  
18 across geographies and within geographies for delivery  
19 systems with respect to so-called supply-sensitive services  
20 suggests that there's some geographies that are creating  
21 equal levels of measurable health and patient satisfaction  
22 while spending 30 percent less per Medicare beneficiary on a

1 maximally risk-adjusted basis.

2           But if drill deeper, what the Dartmouth people are  
3 telling us is that the differences primarily relate to areas  
4 in which effectiveness research and cost-effectiveness  
5 research have not yet touched. Questions like, for patients  
6 that are borderline with respect to whether they need to be  
7 in the hospital, do you put them in? Patients that are  
8 borderline with respect to whether or not they need ICU  
9 care, do you move them into the ICU? With what frequency do  
10 you bring back chronically ill patients to monitor them for  
11 more frequent office visits? What's your threshold for  
12 referring somebody from a primary care physician to a  
13 specialist? It's in those categories of medical decision-  
14 making that most of the variation in supply-sensitive  
15 services, and this 30 percent guesstimate on opportunity for  
16 Medicare to save through reproducing the practice patterns  
17 of the lowest spending deciles occur.

18           Why don't we have more effectiveness and/or cost-  
19 effectiveness research with respect to these basic questions  
20 around which so much variation in spending seems?

21           DR. NEUMANN: My theory is a lot of it's  
22 reimbursement driven. A lot of studies in our database, for

1 example, the 40 percent on drugs fall into the categories of  
2 is drug X cost effective for condition Y, often sponsored  
3 by, but not always, but often sponsored by the companies  
4 involved, because they want formulary placement, they want  
5 reimbursement. I agree, the studies that need to be done  
6 are the kinds that you described, much more richly  
7 descriptive about the strategies and where patients are  
8 going. The problem in the past is that there hasn't been a  
9 great incentive for anybody to get reimbursed for that  
10 procedure and probably requires the payers and perhaps the  
11 government to do those studies. Conceptually, you could do  
12 that study with all the descriptive richness that you  
13 described.

14 DR. EDDY: I'm not sure that we really disagree  
15 and probably wouldn't if we could talk more. I'll just say,  
16 even if it might be feasible, those are inherently harder  
17 cost-effectiveness analyses to do because they involve the  
18 software, if you will, of medical practice. When you talk  
19 about thresholds, borderlines, frequencies and so forth,  
20 they're not hard technologies like giving a drug or putting  
21 in a stent. It takes a much more powerful model to do it  
22 and get it right.

1           Also, the answer you will get will vary from  
2 setting to setting because these have to do with what the  
3 specialists are, and how much they charge, and things like  
4 that. So you can get an answer in New York and have vary --  
5 get an answer at Memorial Sloan-Kettering and have it vary  
6 quite a bit from an answer in the Joslin Clinic, for  
7 example, or something like that. So they are more difficult  
8 to do, and I think we ought to recognize it as an area that  
9 would be harder for cost-effectiveness analysis to make  
10 inroads in than some of the other technologies.

11           MR. SMITH: This was both provocative and very  
12 helpful. David, I share the pessimism, skepticism that you  
13 expressed a minute ago about a bright edge opportunity in  
14 the near future here. Peter, I was struck both in your  
15 paper and your remarks about the observation that we're  
16 beginning to do this sub rosa anyway. But when Nancy-Ann  
17 asked whether or not we ought to proceed with some attempt  
18 to forge a national consensus on this both of you seemed to  
19 think that that was both appropriate and, to some extent,  
20 Peter, I think you more sharply suggested it was necessary.  
21 That we couldn't take full advantage of the potential here  
22 unless we're able to do this above-board and explicitly.

1           I wanted both of you to reflect on that a little  
2 bit, but I'd also like to ask the clinicians here Alan, Ray,  
3 Mary, to what extent you think Peter's observation about the  
4 availability of the information finding its way into  
5 clinical decision-making anyway, to what extent you share  
6 that observation? And is the political cost, political risk  
7 associated with a much more explicit effort worth it, given  
8 your judgment about the extent to which this kind of  
9 information and analysis is finding its way into the kind of  
10 decision-making that you and your peers are making today?

11           DR. NEUMANN: First, I suppose I don't want to  
12 convey the impression that I'm very optimistic that we'll  
13 start using this soon. I probably agree more than not with  
14 Dr. Eddy. This is going to take a long time. It's not  
15 going to be easy. I don't think we're anywhere close to  
16 having a bright line where we're going to say this new  
17 technology is effective marginally, enormously costly,  
18 therefore we won't cover it. Certainly not for certain  
19 kinds of conditions where you have a patient whose already  
20 ill.

21           I do think take there are opportunities to use it  
22 in prevention, to inform frequency of screening, for

1 example, maybe -- we talked about formularies -- to inform  
2 where somebody is on a formulary, which drug they get first,  
3 which drug they get second, and so forth. Maybe to inform  
4 other kinds of conditions on coverage, even coverage in  
5 settings or coverage with certain other criteria. But I do  
6 think there's movement, and the fact that we're discussing  
7 this today is one reflection of that movement. I think were  
8 inching our way forward and there will be a lot of  
9 resistance.

10 DR. EDDY: Just make a quick comment. For quite a  
11 while I've thought that we really should address this head  
12 on and, in a sense, put the country into therapy and really  
13 help it come to terms with this, and I've bloodied my head a  
14 fair amount beating it against various walls and I guess I  
15 decided to stop. Ideally it should be done that way.

16 On the other hand, I think that if we're really  
17 going to make progress in the near term, meaning over the  
18 next five to 10 years, I just think we need to take a soft  
19 approach. But I'm very conflicted about that because the  
20 intellectual in me wants to do it the right way. The  
21 practical person in me says, it just hasn't worked over all  
22 these years and we probably have to choose a more indirect

1 way to approach it.

2 MR. HACKBARTH: It almost seems like there's a  
3 catch-22. On the one hand, these are very difficult issues  
4 to have the sort of national debate that Nancy-Ann referred  
5 to, envision Congress deciding explicitly that we're going  
6 to do this and the quality threshold is whatever it might  
7 be.

8 On the other hand, I often hear from people in the  
9 private sector running health plans that it's very difficult  
10 for them to do without government leadership because it's  
11 not perceived as legitimate if it's done by a private plan;  
12 it's potentially tainted by economic incentives and the  
13 like. Please react to that.

14 DR. EDDY: So here's an idea, setting aside the  
15 methodology of cost-effectiveness analysis, can you just  
16 make a statement that costs are important and rationing-type  
17 decisions simply have to be made? In a sense, just  
18 legitimize the concept.

19 MS. RAPHAEL: I think in line with what you were  
20 saying, you have to also legitimize the process, and I don't  
21 think we yet have a legitimate process. In fact I would say  
22 we're going in the opposite direction, because given the

1 recent furor over Vioxx and Bextra I think people have even  
2 less confidence in the process. So I think it's also  
3 important, if we're going to have a public process that  
4 buttresses even private decision-making that we think  
5 through what would be a process that would be legitimate,  
6 that would incorporate the stakeholders, that could revise  
7 decisions, because I think it's important that you have a  
8 process to review and come back to decisions. So I think  
9 that has to be part of any discussion we would have.

10 DR. MILLER: If I could comment for just a second,  
11 because this now hits where I was keeping notes, trying to  
12 follow along what -- something that the Commission could do.  
13 This is three thoughts. I had a lot of other thoughts and  
14 questions but at least three things that occurred to me.

15 One was trying to comment on what a good process  
16 would be. So rather than saying, you need to ration, you  
17 might begin to try to break down some of the mistrust and  
18 the concerns that often get in the way by saying, there may  
19 be a way to do this that is a better way to do this, and  
20 start talking about what a process like that would look  
21 like. That's not completely different than some of things  
22 we're talking about even in our pay for performance where we



1 referred to it, didn't spend as much time drilling into that  
2 but we certainly talked about the need to carry it on.

3           A second point that occurred to me as I was  
4 listening to all this is maybe pointing in directions where  
5 you might put your first focus. A different word I think I  
6 needed there, but you might look first at these types of  
7 things, or these areas might get the most fruitful. Again,  
8 not calling it but saying, these are the places to devote  
9 the first efforts to.

10           Then finally, and this is a question, it struck me  
11 that one piece that is crucial to benchmarking the models,  
12 getting the information out there underlying a lot of this  
13 is the clinical trial and how the clinical trial is  
14 structured, and whether there's something that the  
15 Commission could say about how trials should be run and  
16 brought to the federal government for approval through the  
17 FDA, through payment processes at CMS, the kinds of  
18 information that would be included in that, because that  
19 struck me as a linchpin to a lot of the models as well as  
20 the information. But I don't know if other people saw that,  
21 the head-to-head type --

22           DR. NEUMANN: Just a couple of quick comments.

1 One, I agree with both of you about process being key here,  
2 and experience with process in other countries and also with  
3 Medicare with the national coverage decisions I think has  
4 shown the importance of it, but also some of the elements  
5 that would comprise good process: transparency,  
6 participatory process with ability to comment for  
7 stakeholders, appeals once a decision is made, pre-  
8 specifying criteria and gaining that legitimacy. All of  
9 that I think is right.

10           Secondly, about the clinical trials, you remind  
11 me, one, that Medicare has now been moving to coverage under  
12 protocol and coverage with much more strict conditions about  
13 data collection. While not cost-effectiveness per se, in  
14 many ways it's trying to get at a cost-effective solution,  
15 and in many ways I think the notion that we can or cannot  
16 use cost-effectiveness, or Medicare can or cannot is in some  
17 sense a false choice. That there will be ways in which to  
18 make decisions, coverage decisions, payment decisions,  
19 probably and certainly decisions that could be informed by  
20 cost-effectiveness analysis. So we'll cover, but only for  
21 those people who meet the clinical trial conditions, or  
22 we'll cover but we'll put all the people into a new clinical

1 trial or registry or data collection effort and learn more  
2 and make another decision in a year or two, that kind of  
3 policy.

4 DR. STOWERS: Just to answer David's question. I  
5 really believe that at least from our perspective as a  
6 provider we're very sensitive to the cost-effectiveness of  
7 care, and I do think there's, as was mentioned before, kind  
8 of a confidence issue out there about it. I think,  
9 obviously, the doctors don't have the data or the model to  
10 go off of so there is some confidence added when major  
11 payers like Medicare, CMS, take on a payment policy. That's  
12 why the rate of pneumovax went up considerably when it was  
13 decided to be covered. It wasn't just the \$5 or \$6 that it  
14 cost for the shot or that kind of thing. There was a  
15 message sent by CMS at that point that they had confidence  
16 that it was a cost-effective thing to do.

17 I hate to raise an ugly head here that hasn't been  
18 brought up that does happen a lot in clinical. As much as  
19 we talk cost-effectiveness, when it comes to physicians  
20 making their decisions, in the tort system that we're in,  
21 cost-effectiveness is not taken into account. So 20 years  
22 ago if I had a swollen ankle come into the emergency room I

1 didn't x-ray it if I really didn't have the clinical signs  
2 of being fractured. I would wrap it, cold therapy, do that  
3 kind of thing. If it's bothering you in a day or two we'll  
4 get some x-rays of it. Today you x-ray it. Now is it cost-  
5 effective to x-ray every swollen ankle?

6 I only use that as one example. But until our  
7 legal system and that kind of thing also begin to accept  
8 cost-effectiveness as a legitimate part of the decision-  
9 making process that the physician goes through, or the  
10 provider, the hospital, home health or anyone else, I think  
11 that's a another major hurdle that we have to cross out  
12 there that just hasn't been mentioned today but I think it  
13 needs to be as we go down the pike on this particular issue,  
14 if we're looking for confidence from those who are making  
15 those decisions towards cost-effective care.

16 I didn't know if you had any comment on that.

17 DR. EDDY: A little bit, yes. First of all, your  
18 point is exactly right, the tort system is just not aligned  
19 with cost-effective medical care. It is not possible to  
20 bring it up explicitly as a defense, but I think it is  
21 possible to incorporate cost-effective thinking into ways  
22 that would protect physicians through guidelines, because a

1 physician is protected if they're following a nationally-  
2 accepted guideline or a commonly-accepted practice. So if  
3 you get good cost-effectiveness thinking into the guideline,  
4 then I think, in my experience -- I've testified in some of  
5 these trials -- it works.

6 DR. STOWERS: I agree.

7 MS. BURKE: Just one thing in follow-up to Mark's  
8 summary of how we might begin to think about this, but also  
9 Carol's concern and follow up on the process issue, that  
10 legitimacy to the process will help move us along in a  
11 variety of ways.

12 We have a tendency, and I've heard it again this  
13 morning, but we have a tendency to try to talk about these  
14 issues in very separate boxes. We have a quality  
15 conversation and we spend a day talking about quality, and  
16 this morning we have a conversation about cost-  
17 effectiveness. It is rare that we consciously combine those  
18 two things.

19 I think one of the issues as we go forward and as  
20 we think about the issues that Mark has raised about how we  
21 would, as a commission, begin to focus on these issues and  
22 move it forward is I think we have to consciously begin to

1 link those two things. Because the issue around cost-  
2 effectiveness must also reflect decisions about quality.  
3 That there is a direct relationship to choosing the right  
4 kinds of things because they're effective, both with respect  
5 to cost but also with respect to the quality of the care  
6 that's being delivered. And whether we begin to think about  
7 it in the context of pay for performance and link it  
8 directly to quality decisions, performance that's based on  
9 both cost, the integration of cost sensitivity, but perhaps  
10 more importantly, the quality issue, people have to begin to  
11 think of these things together.

12 I think we consciously have to begin to combine  
13 them in our conversations, and I think we tend to think in  
14 those boxes. I don't think we believe it, but I think  
15 that's the way we frame it and I think we need to, as we  
16 approach it, as Mark suggests, in looking at ways we can  
17 begin to apply it to our work. I think we have to  
18 consciously begin to connect those two things in our  
19 conversation.

20 MR. HACKBARTH: To me that's part of the  
21 intriguing aspect of pay for performance and the use of  
22 guidelines. It's one of those places where you can readily

1    imagine the two conversations coming together.  And if we're  
2    using pay for performance as a way to reshape the system and  
3    move it in a particular direction, it would sure be nice if  
4    we could move it in a direction that incorporated cost-  
5    effectiveness thinking.

6           DR. EDDY:  Just to give you a one-liner on that,  
7    the questions around pay for performance are, how much do  
8    you pay for how much performance for which technologies?  
9    That is an ideal place -- not only is it an ideal place to  
10   insert cost-effectiveness, but if you don't do it you could  
11   easily, because this is a guideline with teeth, send  
12   everyone going off in the wrong direction.

13           MR. MULLER:  Just in follow-up to Mark and  
14   Sheila's comment, I would like to urge us in terms of our  
15   comparative advantage to not get too focused on the  
16   pharmaceuticals and the drugs, and especially with Part D  
17   coming and so forth.  There will be a lot of scrutiny there  
18   just because it's there.  I think some of the comparative  
19   advantage, given the work we've been doing the last couple  
20   years, is in fact in the other areas.  As David said,  
21   tougher areas to try to measure, but I think given the work  
22   we've been doing we may be the only one around -- that's too

1 much. We may have a comparative advantage in looking at  
2 those other areas that were referenced in Arnie's remarks  
3 and my remarks earlier.

4           So I think there's a tendency because FDA is out  
5 there in that process on the front page of the New York  
6 Times all the time to want to weigh in on that, but these  
7 other processes, imaging, and diagnostics and surgical  
8 technique, none of which have anywhere near the scrutiny  
9 that a Vioxx decision has, and they get out there very fast.  
10 I'm not trying to defend how they did the Vioxx thing but  
11 there's a lot of other things that get into practice with  
12 much less scrutiny, far more conflict of interest, and just  
13 because they don't have a public process to legitimize it is  
14 there's not a process to criticize.

15           I think we have to look at those things that  
16 really drive costs that in many ways are under the scrutiny  
17 that the FDA gets. So we shouldn't just be looking for the  
18 keys under the lamppost but we looking where in fact the  
19 real drivers are.

20           DR. EDDY: I'd like to close with a big picture  
21 comment. There's obviously a lot of uncertainty and a lot  
22 of difficulty here, and I would just point out that any



1 action you take, whether it's a broad frontal attack or you  
2 just have a single beachhead with something like pay for  
3 performance, and even if you don't know the exact effect,  
4 for example, on the budget, without question, if it's done  
5 at all right, you will increase the ratio of quality you're  
6 getting for your costs. That we can be sure of. That we can  
7 be sure of. That is the nature of cost-effectiveness  
8 analysis, so it will achieve that.

9 MR. HACKBARTH: Any final comment, Peter?

10 DR. NEUMANN: I would agree, and I commend you for  
11 discussing it today and look forward to more in the future.

12 MR. HACKBARTH: Thank you very much. It was  
13 outstanding presentations and great, thoughtful comments.  
14 Thank you very much for coming.

15 Next up on the agenda is the mandated report on  
16 critical access hospitals. We're going to need to press  
17 ahead since we took some extra time on the first session.  
18 Jeff, would you like to borrow my tie?

19 DR. STENSLAND: I'll tell you the story on the tie  
20 later.

21 MR. HACKBARTH: I have a guess. Just so this  
22 isn't a private joke. Jeff has a new daughter that's what?

1 DR. STENSLAND: Three weeks old.

2 MR. HACKBARTH: You can figure out the rest of  
3 what happened to Jeff's tie.

4 DR. STENSLAND: Good morning. Today I'm going to  
5 talk about critical access hospitals and our mandated study.

6 The Congress has mandated that MedPAC produce a  
7 report on the rural provisions of the MMA by December 2006.  
8 As an interim step we are also required to produce a report  
9 specifically on the critical access hospital provisions of  
10 the MMA by June 2005. In today's meeting I will review the  
11 current status of the CAH program, discuss how Medicare  
12 payments have increased to converting hospitals, present  
13 data on the improved financial performance of converting  
14 hospitals, and discuss some policy issues regarding the CAH  
15 program.

16 There are several restrictions on which hospitals  
17 can become CAHs but most are not binding. CAHs must have an  
18 average length of stay of four days or less. However, most  
19 CAHs have swing beds. The CAH can discharge Medicare  
20 patients to post-acute status. The same patient can stay in  
21 the same bed and generate the same Medicare reimbursement.  
22 CAHs must also be 35 miles by highway or 15 miles by

1 secondary road or be declared a necessary provider by the  
2 state. Essentially, all small, rural hospitals have been  
3 designated as necessary providers. Therefore, the distance  
4 criteria is almost never binding.

5 CAHs must be in rural areas. However, a state can  
6 declare any town rural for CAH purposes, even if it is in an  
7 MSA. Hence, about 10 percent of CAHs are in MSAs. Many of  
8 these are in fairly rural census tracts of the MSA.

9 The binding constraint is that CAHs are limited to  
10 25 beds. Because this is usually the only binding  
11 constraint, over two-thirds of the nation's general and  
12 surgical hospitals with under 1,900 admissions per year have  
13 converted to CAH status.

14 Back in 2000 we had 139 CAHs, but the program has  
15 grown rapidly from 2000 to 2001 and to 2002, 2003, the  
16 beginning of 2004, and the end of 2004. At the start of  
17 2005 we had approximately 1,070 CAHs. As you can see, some  
18 of these CAHs are in isolated rural areas of the country and  
19 some are fairly close to other CAHs. In addition, some CAHs  
20 are close to PPS hospital. The point being there's a great  
21 diversity amongst the different types of hospitals and their  
22 location in the CAH pool.

1           This figure illustrates how close CAHs are to  
2 other hospitals. Most CAHs are between 15 and 25 miles from  
3 another hospital. However, we did identify 151 CAHs that  
4 are 15 or fewer road miles from the nearest hospital.  
5 Again, they become CAHs through that necessary provider  
6 provision I discussed earlier.

7           Why do hospitals convert to CAH status? Hospitals  
8 primarily convert to CAH status to increase their Medicare  
9 payment. Conversion tends to result in large increases in  
10 payments for outpatient services. Payments for outpatient  
11 services include payments for laboratory, therapy, and for  
12 physician being on call. For the on-call payments to be  
13 reimbursable, the providers must be within a 30-minute drive  
14 of the CAH, unless the CAH is in a frontier area, then the  
15 provider can be a 60-minute drive away.

16           Payments for post-acute care to patients in swing  
17 beds also increased substantially. But payments for  
18 inpatient services often do not increase substantially  
19 following conversion because acute care costs under CAH cost  
20 accounting are often close to prospective payment rates.

21           We compared changes in outpatient payments for 498  
22 hospitals that converted to CAH status between 1998 and 2002

1 with 551 similar hospitals that did not convert. The  
2 comparison hospitals were all located outside of core urban  
3 areas and had received 1,000 or 900 fewer discharges, which  
4 is the largest number of discharges for a CAH in 2003.

5 From 1998 to 2003 we see that outpatient payments  
6 for certain services rose 69 percentage points faster at  
7 hospitals that converted to CAH status and received cost-  
8 based reimbursement. There are several potential reasons.

9 First, CAH Medicare payments were about \$100,000  
10 less than reported costs in 1998.

11 Second, CAHs received reimbursements for on-call  
12 payments located outside of the hospital. PPS hospitals  
13 don't.

14 Third, CAHs have lower incentives for cost control  
15 due to cost-based reimbursement.

16 And fourth, CAHs may be increasing service  
17 offerings due to increased prices they receive for those  
18 services. We will report further on how volume has changed  
19 at CAHs in our April meeting.

20 I should note that the above figures may under-  
21 estimate the true growth in outpatient revenues because they  
22 exclude payments for laboratory and therapy services which

1 were paid on a fee schedule in 1998.

2 MR. HACKBARTH: Jeff, could I just ask you a  
3 question about that? So these changes are a function of  
4 both unit cost growth and volume changes?

5 DR. STENSLAND: Right. So this is the overall  
6 effect and we're going to try to protect that down in April,  
7 in between volume effect and price effect.

8 MR. HACKBARTH: Bill has corrected me that these  
9 are the payments as opposed to any measure of cost.

10 DR. SCANLON: The reason I brought it up is  
11 because knowing the margin changes, it says a lot about what  
12 costs are doing.

13 DR. STENSLAND: Swing bed payments to CAHs -- for  
14 those of you who don't know, swing beds are beds in small,  
15 rural hospitals that can be used for acute care or post-  
16 acute care. These swing bed payments at CAHs rose to  
17 slightly over \$1,000 a day. A 40 percent increase in swing  
18 bed days plus a roughly \$700 increase in payments per day  
19 fueled the \$463,000 increase in swing bed payments. Because  
20 CAH cost accounting allocates a large amount of cost to  
21 swing beds, the remaining costs allocated to acute beds are  
22 often not much more than PPS payments. Therefore, acute

1 inpatient payments did not rise significantly following  
2 conversion.

3           Looking at this slide you may ask, what are CAHs'  
4 incentives to increase swing bed use? When a hospital has a  
5 swing bed patient stay one additional they will receive  
6 roughly \$1,000 in additional revenue for that day. However,  
7 a swing bed day or any type of patient day results in  
8 spreading the hospital's fixed costs over more inpatient  
9 days. Hence, the expenses allocated to Medicare acute days  
10 will be reduced when Medicare swing days are increased.  
11 Accounting for this reduction in payments for existing  
12 Medicare acute patients, the net increase in Medicare  
13 payments for an additional post-acute swing bed day may only  
14 be \$400 or \$500 per swing bed day. This is approximately  
15 \$100 to \$200 more than SNFs receive for providing similar  
16 care.

17           This issue of reducing payments per Medicare day  
18 when patient days increase is most troubling when applied to  
19 charity care. The financial incentives to provide charity  
20 care at CAHs differ significantly from the financial  
21 incentives at traditional hospitals. When a charity care  
22 patient is treated by a traditional hospital, the hospital

1 must absorb the marginal cost of treating that patient,  
2 primarily supplies and nursing time. When a charity care  
3 patient is admitted to a CAH, the hospital must first absorb  
4 the marginal cost of serving that patient, and second,  
5 absorb a reduction in Medicare reimbursement. The more  
6 charity care the CAH provides, the less Medicare pays. This  
7 is a troubling incentive inherent in cost-based  
8 reimbursement.

9           The slide presents an over-simplified example of  
10 how increased care for the uninsured reduces Medicare  
11 payment rates. First, assume a CAH has 1,995 inpatient  
12 days, that's acute and post-acute, of which 1,200 are  
13 Medicare days. If the hospital had \$1 million in fixed,  
14 routine costs, the hospital would receive \$601,534 from  
15 Medicare to recover routine costs. However, if the hospital  
16 admitted one more charity care patient who stayed for five  
17 days, the share of the \$1 million allocated to Medicare  
18 patients would decline and Medicare payments to the CAH for  
19 routine costs would fall by \$1,534. In this example,  
20 Medicare payments falls by roughly \$300 for every day a  
21 charity care patient stays in the hospital.

22           We do not know whether this incentive results in



1 rural hospitals having slightly more restrictive charity  
2 care policies for non-emergency care. However, we can see  
3 how this creates a strong incentive for CAHs to discharge  
4 charity care patients quickly and reduce the total number of  
5 uncompensated care days in the hospital.

6 CAHs have a tendency to expand services where they  
7 receive increased payments under cost-based reimbursements  
8 and drop services that are less profitable under cost-based  
9 reimbursement. For example, a University of Minnesota study  
10 found that CAHs are expanding imaging, laboratory, and  
11 rehabilitation services, all of which are cost based. We  
12 found that these same hospitals slightly reduced their  
13 offerings of obstetric, SNF, and home health services.  
14 Offering these last three services would result in a  
15 hospital's overhead being allocated partially to these  
16 services and would cause a slight reduction in Medicare  
17 inpatient and outpatient payments to the hospital. The  
18 changes in service offerings at CAHs are consistent with  
19 their financial incentives.

20 In total, payments for inpatient, outpatient, and  
21 swing bed services rose 47 percentage points faster at CAHs  
22 than comparison hospitals. As we see on the following

1 slide, the rapid growth in Medicare payments was accompanied  
2 by an increase in total profit margins.

3 This is the real success of the CAH program on the  
4 slide. When we look at CAH financial performance we focus  
5 on all-payer margins for two reasons. First, we wanted to  
6 see if converters appeared to have better overall financial  
7 performance and a lower chance of closure.

8 Second, changes in Medicare margins are difficult  
9 to interpret because conversions to CAH status results in a  
10 change in cost accounting rules. If we looked at Medicare  
11 margins it would not be clear the extent to which a change  
12 in Medicare margins is due to a change in cost accounting or  
13 to a change in actual financial performance.

14 Prior to conversion, many critical access  
15 hospitals were facing low volumes, high costs, and low  
16 margins. Following conversion, Medicare payments and profit  
17 margins increased substantially. With improved profit  
18 margins, closures have almost ceased. We are only aware of  
19 one closure in 2004 and a for-profit entity is considering  
20 reopening that CAH.

21 We can conclude that the CAH program has been  
22 largely successful in achieving its mission of keeping rural

1 hospitals open. However, some of the hospitals the program  
2 is keeping open may not be critical for patients' access to  
3 care.

4           The 2003, CAHs received approximately \$2 billion  
5 of cost-based payments; 17 percent of those payments went to  
6 hospitals located 15 or fewer miles from another provider.  
7 Fifteen percent of payments went to hospitals more than 35  
8 miles from another provider. In 2005, we expect cost-based  
9 payments to CAHs to be approximately \$4 billion. Cost-based  
10 payments to CAHs are expected to roughly double, primarily  
11 due to an increase in CAHs, but also due to an anticipation  
12 of increased costs per CAH. Payments per CAH have  
13 historically risen by more than 10 percent per year.

14           Spending additional Medicare dollars to keep small  
15 hospitals open when they are more than 35 miles from the  
16 nearest alternative source of care is relatively  
17 uncontroversial. Keeping hospitals open that are 15 or  
18 fewer miles from another hospital is a more difficult  
19 decision. If quality improves with volume, then merging  
20 small hospitals that are close to one another may be  
21 beneficial. The key question is whether the benefits of  
22 increased volume and cost savings outweigh the burden of

1 additional travel time for beneficiaries. In our April  
2 meeting we will discuss the quality of care and patient  
3 volumes at CAHs.

4 Starting in 2006, the MMA requires that states  
5 will no longer be able to declare to new CAHs necessary  
6 providers. However, the 151 hospitals that are less than 15  
7 miles from another hospital will be grandfathered in as  
8 CAHs. The Commission may want to consider whether having  
9 low volume providers close to one another is the best way to  
10 care for Medicare beneficiaries, and whether CAHs should be  
11 15 miles from all other providers.

12 The Commission may also want to discuss changes in  
13 the payment for post-acute patients in swing beds. A  
14 typical CAH will receive a net payment of \$100 to \$300 more  
15 per swing bed day for post-acute patients than local SNFs  
16 receive for post-acute care. Twenty-eight percent of CAHs  
17 themselves have a distinct part SNF. Hence, payments for  
18 two patients receiving identical care in the same building  
19 may differ. Medicare may pay \$300 for one more SNF patient  
20 day and pay \$450 for one more swing bed patient day. An  
21 alternative to cost-based payments for post-acute care  
22 patients is to pay CAHs the same rate that is paid to local

1 SNFs. However, this would result in a reduction to CAHs  
2 payments from Medicare.

3 A third issue to discuss is the profit margin  
4 provided to CAHs. Currently, CAHs receive 100 percent of  
5 allowable Medicare costs. As costs go up, their Medicare  
6 profits go up. This can create an incentive to have a  
7 highly leveraged facility, as was the case with SNFs when  
8 they received cost-based reimbursement. An alternative to  
9 paying hospitals a 1 percent return on their costs would be  
10 to pay hospital's return on the equity in their physical  
11 assets; physical assets minus liabilities. Under this  
12 system, when members of the community make donations to  
13 their CAH and the hospital therefore reduces its debt it  
14 would not have a reduction in Medicare payment rates. The  
15 rate of return on equity could be set so that average  
16 payments to CAHs do not changed but incentives would  
17 improve.

18 One way to avoid the problems with cost-based  
19 reimbursements is to provide CAHs with a single, lump sum  
20 payment. Hospitals with under 25 beds that are more than 15  
21 miles from another provider could to be given a fixed  
22 payment. For example, \$500,000 per year, plus the

1 prospective statements given other hospitals. The fixed  
2 payments would help defray the cost of providing standby  
3 emergency room service in a low population density market.  
4 If our objective is to retain access to emergency room  
5 services, we could pay directly for standby emergency  
6 department capacity.

7           There are several advantages to this approach.  
8 First, CAHs would have stronger incentives to control costs.  
9 Second, providing charity care would no longer cause  
10 Medicare payments to decline. Third, Medicare revenue would  
11 be less volatile because it's tied less to patient volume.  
12 Fourth, it would provide rural communities with more  
13 flexibility in how they want to structure their local health  
14 care system and the relationships with nearby facilities.  
15 They would no longer need to retain high volumes in  
16 services, such as imaging or swing beds, to cross-subsidize  
17 the emergency department.

18           So to summarize, I think we have at least four  
19 discussion topics which I'd like to hear your thoughts on.  
20 The first is requiring all CAHs to be 15 miles from other  
21 hospitals. The second is setting post-acute care rates for  
22 CAHs equal to those of local SNFs. The third is paying a

1 return on equity rather than a return on cost. And the  
2 fourth is a change to a fixed subsidy rather than cost-based  
3 reimbursement.

4 Thank you.

5 MR. HACKBARTH: Jeff, let me ask a question  
6 related, I think, to the first one. To the extent that we  
7 have more CAHs and that they serve more patients, is there  
8 not an impact on the non-CAH hospitals that are close to  
9 them, many of which are small themselves? So assume for a  
10 second that there's a finite pool of patients, and if we're  
11 shoring up the CAHs, that means there are fewer patients  
12 that might go to the rural hospital in a little bit larger  
13 town, thus reducing its volume, its ability to add programs,  
14 or its financial well-being. Is there any way to get at  
15 that impact on the adjacent hospitals?

16 DR. STENSLAND: I'll have to think about a way to  
17 get at that, but that certainly is an issue. For example,  
18 when HUD considers making loans to CAHs, one thing they do  
19 is they go talk to the other hospitals around that CAH and  
20 ask out that CAH affects their business, and whether there's  
21 duplicative capacity. And in some cases they decide there  
22 is duplicative capacity so we're not going to make a loan to

1 that facility because we think it would harm the nearby  
2 facility. Then there's also the volume issue and quality.

3 DR. WAKEFIELD: With regard to the subsidy  
4 discussion, I just have to say that I mentioned to Ralph  
5 right before we got into this, just before we started this  
6 formal discussion, that if we're talking subsidies perhaps  
7 that GME subsidy that he's always so fond of could be -- we  
8 could be looking at orders of magnitude for this subsidy for  
9 CAHs. He then responded that he's really quite pleased that  
10 I'm leaving the Commission this year. I'm trying hard not  
11 to take that personally.

12 [Laughter.].

13 DR. WAKEFIELD: Just a few comments and I'll get  
14 you the rest of my comments because there's not enough time  
15 and everyone will become nervous that I'll wax on and  
16 they'll miss their flights, so I won't do that. But I do  
17 want to make a couple of comments about tone, first, of the  
18 chapter, because I think that predisposes at least me to a  
19 certain view about the information that's presented. And  
20 secondly, a few comments on some of the data from the  
21 research you've conducted and maybe some ideas about things  
22 to think about as you continue with the next presentation or



1 the presentation that we'll have in April and the work that  
2 will have to underlie that.

3 I also want to say on the front end that you ought  
4 not construe my remarks as being supportive of this program  
5 exactly the way it currently exists, and that it in fact  
6 supports every single CAH out there as being a well-  
7 documented essential provider. I think like anything else  
8 there's obviously room for aligning the intent of the  
9 program with the way the payment policies are structured,  
10 and certainly there's room for improvement with this as  
11 there is with everything else. So I don't want you to think  
12 that this is just -- I'm hunkering down here and suggesting  
13 it ought to stay just the way it is. That's not what I'm  
14 saying.

15 On the other hand, the flip side of that for me  
16 is, let's make sure that when there are changes that are  
17 made that the brush is not so broad that we do collateral  
18 damage to what was the intent of this particular program,  
19 which was to assure access, essential access to what could  
20 otherwise be construed as a pretty vulnerable population,  
21 that is Medicare beneficiaries. We already know that they  
22 are not the ones who tend to travel down the interstate to

1 go get care 80 miles away, if they can avoid it. The 22-  
2 year-olds in rural areas do, but the 75-year-olds don't  
3 necessarily. So that's the balance that I think we need to  
4 be thinking about achieving, aligning it but being careful  
5 not to do damage to access, which is the original intent of  
6 the program.

7           With that let me just make a couple of comments  
8 about tone, as I said, and then reference some of the  
9 content in the document that we received, and then also some  
10 comments about the findings.

11           In terms of issues that were presented, first of  
12 all, in the chapter we talk about the MMA sunseting  
13 governor's authority to designate small, rural providers as  
14 necessary providers. On page 4 we state that state  
15 officials can increase the flow of Medicare dollars into  
16 their states by declaring more hospitals necessary rural  
17 providers, so they have declared essentially all of them in  
18 order to maximize that Medicare flow.

19           I think the outcome is probably just the same, the  
20 response is the same, but I don't know that that stimulus is  
21 actually accurate. Obviously, that happened with the  
22 Medicaid program in some states, but I have never heard of

1 that as the rationale, that is boatloads of federal Medicare  
2 dollars coming into states, as the rationale for  
3 designation. I do think that there probably is political  
4 pressure teed up and governors probably had to deal with  
5 that, so I'd say that might be fair in some cases. But your  
6 rationale here doesn't mean a whole lot perhaps, but it's  
7 just nothing that I've ever been privy to.

8           Also, I'd say that the simple fact is that with  
9 BBA '97 states were allowed to establish the rural hospital  
10 flexibility program and within that critical access hospital  
11 status. The states had to apply to then-HCFA in order to  
12 achieve that designation. So there were application  
13 criteria that HCFA imposed. It wasn't just governors  
14 designating it and it was done. In fact there was a process  
15 that had to be followed for designation; the designation of  
16 necessary providers, and that those necessary providers had  
17 to be part of a broader rural health plan. So that was a  
18 document and an application process that was in place.

19           CMS allowed fairly loose, some would say,  
20 necessary provider criteria, and once you open that wide  
21 then other hospitals followed suit. So I'm just suggesting  
22 that here the tone is, bad things are going on out in the

1 states, and I would suggest that perhaps some of what  
2 created more CAHs to be designated than what might actually  
3 make sense in terms of the intent of the program could well  
4 have been the fact that we didn't have terribly tight  
5 criteria on the front end against which plans would be  
6 reviewed.

7           Also, states don't redesignate urban hospitals as  
8 rural hospitals. As application process has to be made to  
9 CMS. They can't just say, you're rural, and suddenly for  
10 Medicare purposes it's rural. So we can talk about the  
11 states' role, but I think we also ought to be talking about  
12 CMS, because in fact maybe some of the solutions to some of  
13 these issues may rest there too, may rest with CMS. Not  
14 just with what we're doing out on the frontlines with the  
15 states.

16           MR. HACKBARTH: Mary, could I ask about that so  
17 I'm sure I understand it? The way the law was written, was  
18 CMS granted the discretion to say, we don't like the state's  
19 plan so we won't accept the designations? Or was CMS's  
20 review strictly procedural, so long as the appropriate steps  
21 were followed the discretion was the governors?

22           DR. STENSLAND: When I talked to the people at

1 CMS, that was their impression, they didn't have a lot of  
2 discretion to say no. I think this is actually something we  
3 can actually quantify if we need to because when you look at  
4 the whole issue, we start out with there's maybe 1,500 small  
5 hospitals in the country with 1,900 or fewer discharges, and  
6 about 100 of those are in real core urban areas. Many of  
7 those are physician-owned specialty hospitals like spine  
8 hospitals and that kind of thing. So if we throw those out  
9 we have about 1,400 left. Out of that 1,400 we have about  
10 1,100 have converted already, so we know those were eligible  
11 to convert. Then there's only about 300 left. So we could  
12 even, if we wanted to, we could go through those and see if  
13 there is five or 10 that weren't eligible. But it's going  
14 to be the vast majority of that 300 that's left over.

15 DR. WAKEFIELD: To your question, I don't know the  
16 exact answer. I think worth pitching. Clearly in the  
17 field, I can tell you, that the sense was that there was an  
18 approval process that was put in place and that it wasn't an  
19 automatic; you submit the data and it gets checked off and  
20 rolls through CMS. But I can't say that with certainty so  
21 it would be worth going back and finding out.

22 The other part of that and why I make the point is

1 to say, as we look for solutions we might also be looking  
2 there in terms of future review processes. If there's a  
3 reason to tighten things up that might be a place to try to  
4 leverage appropriate criteria, if you will.

5 MR. HACKBARTH: Let's just try to nail that down,  
6 who was vested with the discretion here, whether it was CMS  
7 or the governors.

8 DR. REISCHAUER: We can also look at the number  
9 that were sent to CMS and the number that got designated.  
10 There's different dimensions to this. One of the criterion  
11 might have been interest in winning the state in the next  
12 election.

13 DR. WAKEFIELD: Not that that would ever happen.

14 But the point is, at least from my perspective,  
15 perception was criteria were really quite broad. Yes, there  
16 were criteria. Criteria had to be met. Criteria were quite  
17 broad. How that really played out you'd probably have to go  
18 back and find out.

19 Just another comment on the mileage issue, the  
20 zero to 15, 15 to 25, 25 and higher, et cetera, and your  
21 good parsing of the hospitals that fit within those  
22 categories. It might be more than what we'd want to do but

1 since you've got two bites at this apple -- I hate to say  
2 it, but 15 miles or 20 miles isn't always 20 miles, isn't  
3 always 20 miles.

4 I do a lot of work with designations on mileage  
5 and minutes to health care facilities because it's so  
6 critical. Where I sit right here I might be able to get to  
7 two different hospitals within 10 minutes as I sit right  
8 here. But as I sit in a mountainous area of the state of  
9 Virginia, that 20 miles might translate to something quite  
10 different in terms of time. So I'll just tell you that out  
11 in a different arena there's a lot of work being done about  
12 what access really means. Mileage is a proxy but as we're  
13 carving these into categories I think that there's some  
14 finer tuning that probably could be done there. At least  
15 you might want to try to look at anyway, instead of just  
16 these firm designations, because I don't think they mean  
17 what on the face you might think they always mean. Which  
18 isn't to say that in that zero to five miles and you've got  
19 two hospitals, that those are legitimate in terms of the  
20 intent of this program. I want to make that point. But I  
21 don't know that it's as black and white as it's listed here.

22 A couple of other issues. On footnote two we say

1 that hospitals can always discharge their patients to swing  
2 bed status and receive the cost-based payment holding the  
3 same patient in the same bed. First of all, that statement  
4 implies, I think, that the hospital is making the decision  
5 when in fact it's probably the physician who's making the  
6 decision, and in fact there are swing bed criteria, clinical  
7 criteria about moving a patient out of a hospital bed and  
8 into a swing bed, and a physician makes that decision.  
9 Hospitals can get nasty letters about quality, and  
10 physicians can get nasty letters too if those criteria  
11 aren't followed. Now you might argue the criteria, but it  
12 is just to say that that footnote suggests something a  
13 little bit more than what I think is actually the case.

14           Next on page six you talk about before hospitals  
15 deciding whether to convert to CAH status they almost always  
16 have a consultant or an accounting firm to estimate whether  
17 their Medicare payments will increase. True enough. In  
18 fact the flex program actually funds some of that activity.  
19 I think that's just good business. I think that Ralph's  
20 shop probably has a good CFO that can run the numbers and  
21 maybe for people who work with him or her. That's not the  
22 case in a lot of these little critical access hospitals.



1 The CEO might be the same person who's out there shoveling  
2 snow in the front of the building, it might also be the one  
3 with pencil and eraser trying to figure out impact. So in  
4 fact the feds deliberately tried to wrap around some support  
5 through the broader flex program to support sound business  
6 decisions being made.

7 I'd say that if you've got a sentence like that  
8 and the tone that it implies; i.e., gamesmanship, you might  
9 as well be tossing it into just about everything that we  
10 write because any time there's a switch in payment people  
11 ought to be doing exactly this. Now where they take it to  
12 might be a different story. But that's what I mean about  
13 tone.

14 On page 13, some personal communication from  
15 Charles Davis at HUD. Again we're saying that they  
16 declined, and you made the comment a little bit earlier,  
17 several potential applicants to the HUD 242 loan program.  
18 But I can't tell from that if that was seven applications or  
19 17 applications or 70 applications. But where that language  
20 leads me is to think, we've got a significant problem here;  
21 potentially it could lead me there. So that's what I'm  
22 talking about when I'm referencing tone.

1           Likewise, the comment about radiology services and  
2 the expansion. Again, true enough. Certainly there is and  
3 has been an investment in technology. I think perhaps a  
4 worst case scenario would be an MRI, and there are CAHs, as  
5 you point out, that have made that particular purchase. So  
6 if we're trying to illustrate the extreme, you've done that.  
7 If we're trying to illustrate what is this investment in,  
8 and you can have different opinions about that, the  
9 investment is more likely to be in CT scans, for example,  
10 with MRIs really being truly the extreme.

11           Also profit margins at the hospitals having  
12 increased substantially. I think maybe a little bit more  
13 word about how to interpret that -- and I know you'll be  
14 building that into the report -- would be helpful. It's  
15 profit margins moving from what to what? If we're moving  
16 from a negative 16 percent margin to a plus 2 percent  
17 margin, that's a pretty substantial increase. That may not  
18 be all bad, pulling them up out of negative and into a low  
19 positive, for example. So some of that kind of explicit  
20 information might be useful too.

21           Last point that I'll make about tone. There's a  
22 discussion of the proposal to provide fixed payments to

1 reduce CAHs' current disincentive that you talked about to  
2 indigent and Medicaid patients. While there might be some  
3 CAHs out there that are closing their doors to those  
4 categories of patients, I can tell you I have never heard  
5 that. I've never heard CAH CEOs talking about the problem  
6 with that, and I've never heard them even alluding to the  
7 fact that that's really a budget buster for us and we're not  
8 going to go there. So I would say if you put that in as  
9 rationale for a new payment methodology we might try to  
10 figure out where that's happening, to what extent that's  
11 happening, and so on, because we're writing that in as part  
12 of the rationale and that just doesn't gibe with what I've  
13 seen.

14           You might also think a little bit about DSH  
15 payments then for CAHs as a way to address -- if you redo  
16 the formula as MedPAC has suggested and then think about DSH  
17 for CAHs as a more direct way of dealing with some of those  
18 issues.

19           That's probably enough on tone. I'll just make a  
20 couple of comments on methodology and then I'll let other  
21 people talk.

22           One, I'm wondering, I guess, what we might learn

1 if our two groups, the converters and the non-converters,  
2 were compared on Medicare allowable costs; costs to costs  
3 rather than payment to costs, and what might that tell us  
4 about the nature of those two groups and what's going on  
5 with them. Right now it's a little bit apples to oranges.  
6 I understand why you're trying to do that, I think. But  
7 there's also an apples to apples comparison that might be  
8 informative to look at too.

9           Secondly, there is a fairly significant difference  
10 in the converters and non-converters, I think, on the  
11 inpatient revenue side, almost twice as much, about \$2.4  
12 million, I think, versus \$1.2 million on inpatient, I think.  
13 That might also suggest that there are some important  
14 differences to look at between those two comparison groups  
15 too. I don't know, but if you drill down there a little bit  
16 more, if I'm not wrong about that, that might be worth  
17 looking at.

18           On page eight, table two you've got a column there  
19 that talks -- this is the table that talks about CAHs  
20 benefitting from large increases in outpatient and swing bed  
21 revenues. You've got a column there that talks about total  
22 Medicare inpatient, outpatient, and swing bed payments after

1 the CAH conversion. That's where I think you're drawing the  
2 \$850,000 more that CAHs have received in payments than their  
3 comparison hospitals. I'm wondering though if you could  
4 also tee up a little bit of rhetoric around the next column  
5 which speaks to change, and that difference is \$505,000  
6 between the two categories, not \$850,000. So what does that  
7 tell us, and is it worth explicating that smaller difference  
8 as well? Something to think about.

9           On page 17 there's a discussion of profits and the  
10 fact that CAHs receive 101 percent of Medicare allowable  
11 costs, a 1 percent profit margin. You might want to put in  
12 there maybe, or in some way that's cleaner and more precise  
13 than this, what that 1 percent amounts to. We estimate here  
14 that there are about 1,055 CAHs and that computes to just  
15 under about \$3.8 million per CAH, I think, and 1 percent of  
16 that then would be about \$38,000 each. The \$38,000  
17 associated with that 1 percent is probably going to buy you,  
18 if you're lucky, a nurse in terms of benefits and wages. So  
19 we're not talking big dollars there. That's sort of a real  
20 rough cut, but it's to try to help the reader get some sense  
21 of magnitude, order of magnitude here in terms of what's  
22 actually occurring there I think.

1           The last comment I'll make -- I've got more pages  
2 but I'll -- you're happy now that I'm suggesting I'll just  
3 send them to them by e-mail. Just a couple of other -- one  
4 more comment or two.

5           The ER on-call doctor issue gets some play in the  
6 text. But I'd say, keep in mind that CAH costs for an on-  
7 call doctor are significantly less than if they're paying  
8 that physician to be there for 24 hours a day on site, and  
9 the cost center is the emergency room, which is typically  
10 not a big -- it's not used heavily typically in most CAHs by  
11 Medicare beneficiaries. Maybe about 20 to 30 percent. You  
12 can verify that. But in some cases, I will tell you,  
13 significantly less than that. That's not just where those  
14 patients typically tend to come through. So that Medicare  
15 utilization is probably pretty low.

16           What does that mean in terms of real dollars to  
17 the Medicare program? Say a CAH pays \$250 per night for one  
18 of its physicians to take calls 365 days a year? The  
19 allowable cost might be just over about \$91,000 for that on-  
20 call doctor. Thirty percent reimbursement of that is about  
21 \$27,000. So again we're focusing attention on something,  
22 but in terms of total dollars there aren't big dollars. You

1 raise the issue, but I think we need to give order of  
2 magnitude to it as well.

3 I guess I'll stop there and maybe reserve the  
4 right to come back in if it's okay.

5 MR. HACKBARTH: You've got a lot of important  
6 information there, and I know Ray has got a lot of things to  
7 say on this as well.

8 What I'd ask each of you to help us with is ways  
9 that the program can be improved and better targeted. I  
10 accept the premise which is, as I understand it, that there  
11 are certain institutions that are necessary to provide  
12 access to people in remote areas. A fear that I have when I  
13 look at those maps and the series of red dots spreading  
14 across the country and many areas of the country is that the  
15 basic purpose is being lost sight of, and ultimately that  
16 threatens the program, it doesn't strengthen it. At some  
17 point it just loses credibility because it's so detached  
18 from its original mission. So if you can help us say, here  
19 are ways that we can achieve that mission, which is a  
20 critical mission, and refine the rules, better target them,  
21 that would be extremely helpful.

22 DR. WAKEFIELD: If I could just add on that point,

1 I'd strongly suggest, and actually I mentioned this to Jeff,  
2 a few people I think he could also talk with, now that  
3 you've got the data to run this by, who might have some  
4 ideas besides us. MedPAC staff have accessed panels of  
5 individuals before -- not to come and talk to us, but where  
6 they've accessed panels of individuals before to get some  
7 input and reaction to data. I think that's critically  
8 important. I've given you names.

9 I'd also deal in that mix, Office of Rural Health  
10 Policy. They certainly have a couple of people over there  
11 who are really expert in this program, and you'd have a  
12 different fed agency perspective about potential changes to  
13 the program too.

14 DR. STOWERS: First I'd like to repeat everything  
15 that Mary said.

16 DR. REISCHAUER: But slower.

17 [Laughter.]

18 DR. STOWERS: I really will try to cut to the  
19 quick here but I've got a few points I think are -- one on  
20 the political pressure thing. On this political pressure, I  
21 think we've got to be real careful where we go on this, that  
22 a town of 2,000 people is going to swing a governor when



1 they're down the road from 50,000 or 100,000 votes for a  
2 particular thing. I think the general consensus here is  
3 everybody does not want these hospitals to close, and  
4 generally there's very little opposition from neighboring  
5 hospitals, and if there is, they don't tend to go down that  
6 path. So I think we've got to be real careful because  
7 politics is votes, and there's not a lot of votes in a lot  
8 of these small communities, so we've got to be real careful  
9 on that one.

10 I have to really add just a tiny bit to this thing  
11 on the government push on this thing. We tend to look at  
12 them like they're going out and playing the system and doing  
13 that kind of thing. But the flex grant is, just so you're  
14 aware, literally mandated the state offices of rural health  
15 to go out and do consults and offer this program to every  
16 single eligible program out there. The consults were paid  
17 for by federal dollars. The consults also were mandated  
18 that the decision to go PPS or stay PPS or go to cost-based  
19 had to also be based on bringing that hospital up to current  
20 efficiencies. If there were behind in accounts receivable  
21 or other managerial problems, that had to be taken into  
22 account before they would get the green light to go on to do

1 that kind of thing. All of this was mandated, and money  
2 from Congress to push the conversion and that kind of thing.  
3 So I think that atmosphere, I agree with Mary, needs to come  
4 across in this chapter, the concerted effort that came out  
5 of HRSA and the Office of Rural Health and all that kind of  
6 thing, to do that.

7 I won't belabor this either, and this was really,  
8 I think, a significant thing that we need to change in the  
9 chapter, at least look at, and that's this idea of net  
10 increase. We've admitted in the chapter that there's not  
11 much increase in the inpatient and payments and that kind of  
12 thing. But even when we talk the outpatient we tend to talk  
13 total dollars that have changed in outpatient here, but I  
14 like Glenn's idea because I think it's very true, there's  
15 kind of a fixed amount of patients out there and a fixed  
16 amount of outpatient work that basically needs to be done.  
17 It may be more of a shift of location, where it's being  
18 done. As one of your slides showed, there's an increase in  
19 laboratory, increase in x-ray that's now accessible to these  
20 rural communities. It would be natural that their volume  
21 would go up because now people are not having to drive 15,  
22 20, 30 miles to get their x-ray done, or even their CT done.

1 I'm not personally aware, although there may be one or two  
2 in the country that have an MRI like she said, but several  
3 have managed to get up to the level of being able to have a  
4 CT. So I would expect the outpatient to go up.

5 It's also attracted a lot of physicians into these  
6 critical access hospitals who are more specializes, because  
7 now they can afford an outpatient suite to do outpatient, so  
8 there's a lot more GI doctors that are traveling out to do  
9 these services one day a week or that kind of thing in the  
10 rural hospitals.

11 So I'm not so much worried about how much more  
12 money is shifting out into these rural communities. I saw  
13 that as a goal of the program as much, as what the total  
14 increase in outpatient services has been to the program,  
15 because that's what we ought to be looking at here is  
16 increased cost to Medicare for doing this.

17 I agree with the order of magnitude thing here.  
18 We've had 1,100 hospitals convert and we talk total dollars,  
19 but the cost per hospital here -- this volume is huge, but  
20 in the other case we need to look at that.

21 Another thing that came out in your slides, I  
22 think it was page 13, on there where we -- I'll wrap this

1 up, Glenn -- and I do have some thoughts on what you were  
2 talking about. When we talk about the total amount of  
3 payments for hospitals, the programs came on because we had  
4 literally hundreds of hospitals in the country being  
5 threatened to close. I'm not so much worried about the  
6 percentage in increase in these hospitals, but now where we  
7 stand in comparison to their comparison hospitals. We get  
8 down to where there's very little difference now, even  
9 though there's been a big percent increase. That was the  
10 purpose of the program.

11 But again, the net cost to the program as we go on  
12 in the future is the difference between in the \$1.06 million  
13 and the \$1.038 million, and it's the ongoing cost to have  
14 this access available that I think we ought to be looking  
15 at, not the increase that's occurred over the implementation  
16 of the program. There's like 1,400 in the nation that  
17 totally qualify and we've already got 1,100 of them, so  
18 there's only 300 potentially out there. The vast majority  
19 of them have had this consult done by the feds and have been  
20 told they're better off to say -- so there needs to be some  
21 magnitude in here of how many still potentially would do  
22 better with cost reimbursement. I would estimate that that

1 is a very small number because almost everyone has been  
2 through this consult process by this time, and have been  
3 told with efficiencies they're better to stay in the PPS.

4 I can't go without saying that I think this  
5 charity reach is really a reach. They're the only hospital  
6 in the community. I think the cost reimbursement has  
7 allowed them to do more charity care. But to say that  
8 because there's the potential out there that they might have  
9 a cut -- I think we need a lot more solid data before we  
10 would ever -- that they really have stinted on charity care  
11 in their communities.

12 The HUD program, by the way, we have one of the  
13 only two hospitals that have been approved and recently  
14 constructed under the HUD program, and it's within very  
15 close, probably a little too close proximity to a  
16 neighboring hospital. The neighboring hospital was in full  
17 support and became their sponsor hospital. So we've got to  
18 be careful on this HUD statement. There's only been two in  
19 the nation that have opened under the HUD program, so I  
20 agree with the magnitude thing there, that we need to be  
21 careful with that kind of thing.

22 Glenn, I totally agree with you and with Mary that

1 we need to look at the system and be careful, and I think  
2 probably the one main issue is this distance, that has gone  
3 through the governmental process. I would contend that the  
4 35 miles is way too far. I know it was an arbitrary number  
5 in the beginning. I practiced with one 17 miles north of  
6 me, and the other hospital that we went to every day was  
7 almost 40. When you have somebody having a heart attack or  
8 an acute anaphylactic reaction or that kind of thing, by the  
9 time you load them, transport them and that kind of thing 20  
10 miles can be a very long distance.

11 My daughter had an acute allergic reaction with  
12 near anaphylaxis in Tulsa. Would have been in a small town  
13 five years ago. Ended up being transported to a major  
14 medical center. Waited 45 minutes in the emergency room.  
15 Had to go through extensive recovery from that. I'm only  
16 getting around to the thing you're coming to next month and  
17 that's going to be talking quality. I can guarantee you in  
18 the small hospital, the adrenaline and that kind of thing  
19 would have been given immediately, and that the care would  
20 have probably been more expedited and better.

21 The only caution I'm putting there is that the  
22 data out there on quality in these hospitals, for what they

1 do, is somewhat preliminary, but it's showing for what they  
2 do it may even be better, and it's probably not a lot volume  
3 related in that. And that the centers of excellence type  
4 volume is better type principles will not probably apply  
5 here. So I'm just giving some thoughts and word of caution  
6 on that.

7           Glenn, I think, again, that probably tightening up  
8 the process somewhat on distance and being sure there's  
9 consensus from the hospitals around and that kind of thing  
10 are going to be a good thing. I've got a lot of other  
11 things too but I think we've just got to be real careful  
12 with the tone of this chapter.

13           DR. WOLTER: Just a little background -- maybe  
14 it's disclosure. My organization actually manages seven  
15 critical access hospitals, six of them are in southern  
16 Montana and one in northern Wyoming, and in a couple of all  
17 those communities we also employ physicians. In Montana,  
18 which as the chapter said, pioneered the program, of I think  
19 about 53 hospitals in the state, 41 are now a critical  
20 access hospital. I think only three of them would be  
21 affected by tightening up the 15-mile rule, although they  
22 would strongly argue their case, I would think.

1           A couple comments. I would agree, I did think the  
2 tone was a bit overly negative, and the charity care, I can  
3 just tell you, is certainly not in play in anything I've  
4 ever observed. In fact these are not-for-profit community-  
5 governed organizations. There's a huge commitment to that  
6 in a state that has 21 percent of the population uninsured.  
7 That one is really a stretch in terms of what it might be  
8 implying.

9           In terms of the consulting dollars, my  
10 organization would consult hundreds of thousands of dollars  
11 more annually than the critical access hospitals are able  
12 to. They really struggle. They don't have the  
13 infrastructure in terms of resources to do facility  
14 planning, human resources, billing, and accounting,  
15 consulting. I think that's really one of the issues that  
16 they face.

17           As far as the big increase in outpatient payment,  
18 our analysis of that would be, that was where the problem  
19 was. Because under PPS, critical access hospitals more or  
20 less made it on the inpatient side, at least those that I  
21 have experience with. But where they really struggled was  
22 in the outpatient arena. So the cost plus 1 percent has



1 filled a gap that was really the problem that I think  
2 existed. So I would take that information and make sure  
3 it's in an appropriate context.

4 As far as the new service development and services  
5 dropped, of our seven hospitals, four of them often OB and  
6 two have dropped it. They dropped it having nothing to do  
7 with critical access versus PPH, but they would do 30, 35  
8 deliveries a year, very low volume, and anesthesia costs be  
9 \$200,000, \$250,000 a year to try to cover that low volume,  
10 and it just wasn't sustainable to stay in that business  
11 line, especially with some of the advances. So those were  
12 very difficult decisions, I might add, and created a lot of  
13 community consternation, but those decisions were made.

14 As far as moving into other services, I think  
15 there are some similar impulses in these communities that we  
16 see in large urban communities. For example, imaging.  
17 Traditionally, the DRGs coming through a small rural  
18 facility are those DRGs where there is either very minimal  
19 profit or there's a negative. As we have seen in the DRG  
20 system, there's the universe where there's a margin and  
21 there's the universe where there isn't, and they live in the  
22 universe where there's not cardiac surgery, orthopedics, and

1 neurosurgery. So it would be natural for them to look at  
2 services that might make sense in their community where  
3 there would be profit. Certainly, imaging is one of those,  
4 and we have had a couple of our communities and move into CT  
5 scanning.

6           There's a clinical reason for that too. With the  
7 advent of pacts, when there's trauma, having a CT reviewed  
8 seconds later by a radiologist in a larger community 50  
9 miles away can make a huge difference to patient outcome.  
10 So I think there's some common sense to some of the trends  
11 we're seeing. It isn't all about finances, although  
12 certainly some of it would be.

13           On swing beds, it would be fair, I think, for us  
14 to acknowledge that one of the underlying issues on that  
15 thinking is SNF payment. Hospital-based SNF payment,  
16 especially in low volume critical access SNFs, it's a losing  
17 proposition. Although we are quick to throw out hospital  
18 accounting practices as the reason, I can tell you that's  
19 not it. It is that you lose money on the SNF side, so the  
20 swing bed is at least a place to try to get yourself back to  
21 something that's a little bit more reasonable. So we should  
22 acknowledge, I think, all sides to this conversation.

1           As far as return on equity as a possibility, I  
2     don't know how that would work. In our experience, we have  
3     mostly low debt facilities now, but they are not very high  
4     equity facilities because they are 40 and 50-years-old.  
5     They haven't had the dollars to invest in new  
6     infrastructure. They in many cases are grandfathered around  
7     many code violations. They don't have the dollars to put  
8     new technology and information systems in place. And  
9     certainly even the cost plus 1 percent isn't correcting  
10    that. Many of the facilities haven't even been able to fund  
11    depreciation in recent years.

12           With the experience Montana has had, and of course  
13    we were early on in this, we've gone from -- this would be  
14    all the critical access hospitals across the state -- from  
15    the group averaging net negative margins to 2003 there was a  
16    positive 0.19 percent margin. I think that's a total margin  
17    or an all-payer margin, rather, not just a Medicare margin.

18           Then on cost control, I see a lot of incentives in  
19    our facilities to manage their costs aggressively because  
20    they're still so at the margin in terms of their overall  
21    bottom line. It's not like they are seeing opportunities to  
22    really pad anything. So at least I see a lot of cost

1 control activities.

2 Glenn, I would certainly agree with your thesis,  
3 we need to be very careful that what transpires doesn't  
4 endanger the original mission of this, but I do want to be  
5 careful that we have the right tone and information about  
6 where this program really, I think, is succeeding. So those  
7 would be my comments.

8 MR. HACKBARTH: We are well over time. Any urgent  
9 final comments from anyone?

10 DR. SCANLON: Normally, I think I would want to  
11 look at this in terms of these hospitals compared to some  
12 group and see how they're faring, and I think the problem is  
13 that we don't really have a very good comparison. Given  
14 that distance is going to be, I think, a critical part of  
15 our thinking, it would be helpful if we could do some of  
16 these tabulations by the distance to the other hospital, to  
17 know what group we might be affecting by looking at a  
18 recommendation with respect to distance.

19 MS. BURKE: Just one cautionary note, and it's one  
20 that Mary raised. I will take some blame here having been  
21 involved in some of this originally. Certainly, in the  
22 swing bed creation and in some of the issues of treatment

1 for rural hospitals.

2           A mile is not a mile, and I would only raise the  
3 cautionary note that we be careful about using absolutes.  
4 It is certainly something that ought to be considered. It  
5 certainly does raise some appropriate questions. I'm just  
6 like Glenn, I worry about the behavior of some putting at  
7 risk what was a fundamental commitment that I think still  
8 makes sense. But I think that we ought to be very careful,  
9 and the Office of Rural Health is a place where we can go to  
10 understand in fact what the reality is here. In mountain  
11 states and states with horrific weather patterns, there are  
12 real issues that need to be considered that differ depending  
13 on the time of the year and the location.

14           I would agree with you that is an easy way to  
15 start that analysis but I would just caution that we need to  
16 look very carefully at what that mile actually means in all  
17 cases.

18           DR. STOWERS: A final word. I would just like my  
19 final word to be a question, and that I think the chapter  
20 needs to make very clear. That is, if I have two critical  
21 access hospitals that are 14 miles apart and I close one of  
22 them and now all of the people travel to other communities

1 30, 40 miles away, how have I saved Medicare or CMS any  
2 money by closing that hospital?

3           So we're worried about numbers here and even  
4 distances, but if two hospitals are getting along and  
5 they're 12 miles apart, and we're talking saving costs to  
6 CMS here, how have I reduced cost to CMS by having those  
7 people from that community lose their hospital and economic  
8 base and all of that and go to town B? Where's the savings?  
9 I think that's where I'm a little confused, where our  
10 objectives are here. I'm just throwing that out. And what  
11 would the net savings be of closing that hospital to CMS?

12           DR. REISCHAUER: I can give you an answer to that,  
13 although I'm very sympathetic to the points that have been  
14 made. The answer is, some of those people would go to a PPS  
15 hospital. But it's a fraction of 100 percent.

16           MR. HACKBARTH: Thank you, Jeff.

17           Our last presentation is on improving outpatient  
18 dialysis payment policy.

19           Can I see a show of hands among commissioners of  
20 people who urgently need to leave right at the end of the  
21 meeting, or whether we can maybe stay an additional 10  
22 minutes or so? The scheduled end of the meeting is what I'm

1 referring to. The scheduled end of the meeting is 12:15.  
2 If I could get people to stay until 12:30, that would be  
3 helpful. What I would do is shoot to have us out of here no  
4 later than 12:30.

5 MS. RAY: I will try to be brief. This session on  
6 outpatient dialysis payment policy is a follow up on issues  
7 that we raised about the MMA and the new regulations in the  
8 December and January meeting.

9 You've seen this table before. This shows how  
10 outpatient dialysis services are being paid in 2005. We're  
11 going to focus on the bottom row, how Medicare is separately  
12 paying for injectable drugs, and then we will focus in on  
13 how Medicare is paying for the composite rate services,  
14 including the add-on adjustment.

15 First, let's talk about issues with the changes to  
16 drug payment policies. The MMA mandated that providers be  
17 paid acquisition cost. As implemented, there are now  
18 multiple ways to pay for separately billable drugs. Average  
19 acquisition payment is used to pay for most separately  
20 billable dialysis drugs. AAP is derived from average  
21 acquisition cost data gathered by the IG last year. And  
22 average acquisition payment is used to pay for the top 10

1 drugs in freestanding facilities -- that includes EPO -- and  
2 for EPO in hospital-based facilities.

3           However, average acquisition payment is not the  
4 only way Medicare pays for drugs. For drugs other than the  
5 top 10 in freestanding facilities, Medicare pays ASP plus 6  
6 percent. And for drugs other than erythropoietin in  
7 hospital-based facilities Medicare pays reasonable cost. So  
8 this means that payment for drugs, other than  
9 erythropoietin, differs between freestanding and hospital-  
10 based facilities.

11           There may also be concern about the long term  
12 sustainability of the average acquisition payment data.  
13 Like I said, the IG collected this data. This data  
14 represents 2003 acquisition cost for the top 10 dialysis  
15 drugs. The IG is not mandated to go back and update this  
16 data over time. So what that means is that over time the  
17 average acquisition payment may not accurately reflect  
18 acquisition costs if negotiating strategies between  
19 providers and manufacturers change.

20           By contrast, ASP might be a better source of data  
21 in contrast to average acquisition payment data. It is  
22 updated by the agency quarterly. It contains information on



1 all drugs, and it would better reflect providers'  
2 acquisition cost in the future if negotiating practices  
3 change between manufacturers and providers. It's also  
4 consistent with how Medicare pays other Part B providers.  
5 And it would certainly reduce the complexity in paying for  
6 dialysis drugs because it would be just one way to pay for  
7 the drugs; one payment rate.

8           This leads to the issue then, at what level should  
9 ASP be set? In CMS's proposed Part B reg they initially  
10 proposed paying for dialysis drugs and ASP minus 3 percent.  
11 They arrived at ASP minus 3 percent based on the data from  
12 the IG report that found that the four national dialysis  
13 chains, which represented roughly 70 percent of all  
14 freestanding facilities, paid ASP minus 6, and the all other  
15 facilities, which represent 30 percent of facilities, pay 4  
16 percent over ASP.

17           In our comment letter to the agency we raised the  
18 concern that not all providers might be able to purchase  
19 drugs at ASP minus 3 percent and suggested that CMS consider  
20 setting the payment rate at or above ASP to maintain  
21 beneficiaries' access to care. In the final rule, as the  
22 first table showed, the agency retreated and used the IG

1 acquisition cost data to set payment for the top 10 dialysis  
2 drugs in freestanding and EPO in hospital-based. And they  
3 took the 2003 data and they updated it to 2005 payments  
4 rates using the producer price index.

5           This leads us to our first draft recommendation,  
6 that CMS should eliminate differences in paying for  
7 separately billable dialysis drugs between hospital-based  
8 and freestanding facilities, and use average sales price  
9 data to base payment for all separately billable dialysis  
10 drugs.

11           This recommendation is consistent with MedPAC  
12 policy that providers' decisions about site of care should  
13 be on based on clinical, not functional, status.

14           As you can see from the recommendation, we didn't  
15 specify a particular level of ASP however. We conducted an  
16 impact analysis to better understand how aggregate payments  
17 might change if you use different levels of ASP. In our  
18 impact analysis we tried our best to replicate CMS's  
19 approach, and I'd be happy to answer any questions you might  
20 have about the methods we used.

21           One point I do want to raise here, however, is  
22 that our impact analysis includes all drugs provided by

1 freestanding facilities and EPO by hospitals. Our impact  
2 analysis that I'm presenting today does not include non-EPO  
3 drugs provided by hospitals. To replicate CMS's impact  
4 analysis it's necessary to use the payment rate per drug per  
5 unit data, and that data is available for the top 10 drugs.  
6 For non-EPO hospital-based we had to turn to the claims data  
7 to try to derive payment per unit, and we're still doing  
8 this, and we will report back to you in April. But right  
9 now we are looking at the accuracy of that data to derive  
10 payment per unit.

11           So here you see the payment per unit for the top  
12 three drugs. We focused on ASP plus two and ASP plus three  
13 for this month because we thought these were both best  
14 approximations of the average acquisition payment data, the  
15 payment rate already in place, and that would stick to the  
16 spirit of the law in paying average acquisition cost.

17           So you see here the impact and the change of  
18 payment per unit for dialysis drugs. We're comparing this  
19 to pre-MMA payments. So overall, you'll see that under the  
20 current policy of paying average acquisition payment,  
21 payment for drugs went down 13 percent. Again, this is all  
22 drugs provided by freestanding and EPO by hospital-based.

1 You'll see for ASP plus two and ASP plus 3 percent, that  
2 difference is pretty close to the 13 percent.

3 Here is the aggregate change in payments. Again,  
4 this data is preliminary and we'll come back to you next  
5 month with more data analysis. I think what I want to point  
6 out here is, you'll see on the bottom row that the payment  
7 for drugs will vary depending on how you pay for them. But  
8 the story doesn't end here. Remember, I told you we have  
9 this add-on adjustment, so the difference in the pre versus  
10 post-MMA payments is shifted to the add-on adjustment that's  
11 associated with the composite rate. So we haven't lost any  
12 dollars here. These are all designed to be budget neutral  
13 and I will show you that in a couple slides from now.

14 Let's move on to the composite rate. The MMA did  
15 not --

16 DR. MILLER: Just to be clear, so in other words,  
17 even though you see negative signs on these drugs, these  
18 differences get built into the composite right side, and  
19 we're about to move into that discussion. Is that fair?

20 MS. RAY: That's correct. Thank you.

21 Quickly moving on to the composite rate then. The  
22 MMA did not change the difference in the base payment rate

1 between hospital-based and freestanding facilities. The  
2 base rate differs. There is a four-dollar difference that  
3 was mandated when the composite rate was initially put in  
4 place in 1981.

5 We also have concerns about the design of the add-  
6 on adjustment. It's complex. If the intent is for the add-  
7 on to address the cross-subsidy between the profits for  
8 separately billable drugs and the composite rate, then the  
9 two payment rates should be combined. In reality, both the  
10 composite rate and the add-on are added together before  
11 payment will be case mix adjusted beginning on April 1st of  
12 this year.

13 So this leads to our second draft recommendation,  
14 that the Congress should direct the Secretary to eliminate  
15 differences in paying for composite rate services between  
16 hospital-based and freestanding facilities, and that the  
17 composite rate and the add-on adjustment be combined.

18 This recommendation, again, is consistent with the  
19 MedPAC principle of payment not varying across different  
20 sites of care.

21 I just want to point out here that although this  
22 recommendation combines the payment, we don't want to lose

1 sight that we ultimately want to figure out what services  
2 should be in the bundle, particularly the broader bundle,  
3 and that's addressed by our third recommendation that's  
4 coming up.

5           So if you were just to look at the composite rate  
6 by eliminating the four-dollar difference and spreading that  
7 four-dollar difference, the dollars associated with those  
8 treatments across all treatments, just the composite rate by  
9 itself would change by 0.4 percent for freestanding and  
10 decline by 2.7 percent for hospital-based.

11           I want to raise some concerns here about  
12 eliminating the four-dollar difference that have been raised  
13 by some stakeholders. They contend that hospitals are  
14 fallback facilities, and that hospitals treat patients who  
15 were more complex and might be more disruptive than  
16 freestanding facilities. Some stakeholders also contend  
17 that hospitals provide higher staffing of RN's, social  
18 workers, and dietitians, than freestanding facilities.

19           Just to briefly address those points, and I think  
20 commissioners could discuss them if they'd like. First is  
21 concerning that hospitals are fallback facilities. Payment,  
22 beginning in 2005 in April is now adjusted for case mix, and

1 I think that this case-mix adjustment will only get better  
2 over time, particularly as we expand the bundle and case mix  
3 adjust for a broader bundle.

4 Concerning whether or not hospitals provide more  
5 care, I think here, again, Medicare needs to think carefully  
6 about what services need to be included in the bundle, and  
7 that those services are available for patients in both  
8 freestanding and hospital-based facilities.

9 So then if you were to take the recommendation to  
10 the next step and you would combine the composite rate and  
11 the add-on adjustment and you would eliminate the four-  
12 dollar difference you see the three different payment level.  
13 Again, the payment levels differ depending upon how you pay  
14 for a drug because of that add-on adjustment. The add-on  
15 adjustment, one more time, is the excess dollars that were  
16 associated with the drug margin. So the more you pay for  
17 drugs, the smaller the add-on adjustment. That's why under  
18 this scenario, the ASP plus 3 percent is slightly lower than  
19 the ASP plus 2 percent payment rate.

20 So here we are back putting the change in the drug  
21 payment policy, combining the add-on adjustment and the  
22 composite rate, and eliminating the four-dollar difference.

1 Again, you will see that payment slightly differ depending  
2 upon how you pay for the drugs, but that in total this is  
3 done budget neutral so total payments don't differ.

4 Now I'd like to just take you briefly towards  
5 modernizing the payment system. The MMA does not bundle the  
6 composite rate, injectable drugs, and other services  
7 commonly provided to patients. The separate payment, as we  
8 pointed out many times, does not give the right incentive  
9 for the efficient use of services. The MMA, however, does  
10 mandate a three-year demonstration on a broader payment  
11 bundle, and that this demo is slated to begin next year.

12 So our draft recommendation reiterates our  
13 recommendation that we made in 2001, that Medicare should  
14 broaden the payment bundle. And I think some thought needs  
15 to be given here as to whether it should reflect dialysis  
16 care or the care of the dialysis patient. That payment  
17 should account for factors that affect efficient providers'  
18 cost, including case mix, dialysis method, and dialysis  
19 dose. It is very important for Medicare to monitor and  
20 report on the quality of care. And for holding providers  
21 accountable for the quality of care, payment should be  
22 linked to quality.



1           Next month I'm hoping to bring you back some  
2 additional information about purchasing strategies of  
3 dialysis facilities, looking at the impact of using more  
4 current wage indices, and different ways to case mix adjust  
5 a broader payment bundle.

6           MR. HACKBARTH: Nancy, could you talk a bit more  
7 about the relative impact of the series of changes on  
8 freestanding versus hospital-based? There's some pluses and  
9 minuses in terms of eliminating the four-dollar differential  
10 on the other hand, but then on the other hand spreading the  
11 add-on for the drug overpayments across both as opposed to  
12 just the freestanding from whence it came. How does all of  
13 this net out in terms of the relative impact on the two  
14 types of facilities? Did that come out clearly? Do you  
15 know what I'm asking?

16           MS. RAY: Right. I don't have those numbers here  
17 in a table for you. I can get those for you in April. It  
18 does change it slightly. But again, because we picked the  
19 drug payment levels that closely approximated average  
20 acquisition payment, what I can say is the impact of going  
21 from pre-MMA to the current law, that that impact is pretty  
22 similar if you go from pre-MMA to either ASP plus two or ASP

1 plus 3.

2 DR. MILLER: But if you took that in isolation, I  
3 think part of the reason -- to try to talk about this  
4 comprehensively, the thing not to miss in this is -- and  
5 Nancy, make sure I don't miss anything here -- we're  
6 fundamentally rejecting the MMA's approach to this add-on,  
7 where you keep this piece that continues to look at drugs,  
8 estimate the profit, and pour it into the composite rate.  
9 So we're fundamentally saying, for a lot of reasons that we  
10 went through in previous meetings, very complicated,  
11 probably not a great policy, et cetera, so step one.

12 Step two, at the same time we're messing around  
13 with how to pay the drugs. Wrong word. We're saying  
14 rationalizing -- a better word -- rationalizing how we pay  
15 for drugs across the three categories, which also, depending  
16 on the distribution of drugs in the different -- will have  
17 an effect, and also affects what we end up putting in the  
18 composite rate for our one-time fix, if you will.

19 The third thing that's gone on that also changes  
20 the distribution is we're taking the four dollars from the  
21 hospital-based and taking that out and saying that should be  
22 equal, which will send money in the other direction, as it

1 were.

2           Then finally, a little piece that we don't have,  
3 if I understand all of this, is the non-EPO drugs in the  
4 hospital. We are definitely trolling through the data  
5 trying to figure out how to get unit estimates to estimate  
6 that. So giving you a net-net by the types of facilities is  
7 still little bit escaping. But I think your last point is  
8 pretty dominant here. To the extent that the ASP plus two,  
9 plus three is close to acquisition cost, in isolation, that  
10 effect remains the same, and then the offsetting effects of  
11 the four dollars moves the money in the other direction from  
12 hospital-based to freestanding.

13           MR. HACKBARTH: Just to be clear, I think moving  
14 towards a single payment system, regardless of the two  
15 types, I think is a very important goal, but I think we need  
16 to understand the impact as best we can on the different  
17 types.

18           MS. BURKE: Nancy, in anticipating a more detailed  
19 discussion of this in April, following on Glenn's point,  
20 there are a couple of things that I'm not sure I fully  
21 understand and would appreciate understanding as we go  
22 forward. One is the fundamental move from the acquisition

1 price to the sales price and why. What is it inherently  
2 about the acquisition price that makes us -- given that they  
3 are so close, what is it that would have us go from one to  
4 the other? And does that create any strange incentives on  
5 the sales price where this will suddenly encourage certain  
6 kind of behaviors on the pharmaceutical side? I just want  
7 to make sure I fully understand what the impact is of moving  
8 from one to the other.

9           The second question that I would appreciate  
10 understanding as we go into this is the issue around the  
11 removal of the difference in payment between the hospital-  
12 based and the freestanding. We, as I recall -- and I don't  
13 recall the details of it -- have looked at the differences  
14 in quality indicators as we've gone forward in terms of  
15 dialysis patients, and your point that there's an argument  
16 made that on average there has been a higher rate of nurses,  
17 other staffing on the hospital side, I just want to have us  
18 come back to and again relook at what is it that that  
19 information told us? What do we know about whether there  
20 are any differences in quality indicators between hospital-  
21 based and freestanding?

22           To what extent any of that, if there is a

1 difference, and that's what I can't frankly recall from our  
2 earlier discussion -- if there is a difference, to what  
3 extent can we in fact attribute that to a higher ratio of  
4 staffing, things that at least historically was suggest that  
5 there is a direct impact? If you have more nursing hours  
6 there to be a higher quality result. What do we know  
7 particularly about this issue, and how would we apply that  
8 knowledge going forward if we're about to get rid of that  
9 difference?

10 MS. RAY: Let me just clarify. Some stakeholders  
11 contend that hospital-based provide more RN's. I have not  
12 validated that.

13 MS. BURKE: I understand. That's my question is  
14 what do we know from the data, whether that's true or not.

15 MS. RAY: I think to answer your second question,  
16 CMS's clinical performance measures, to the best of my  
17 knowledge, don't differentiate between freestanding at  
18 hospital-based facilities, and that is the information that  
19 we have presented in the past about monitoring the quality  
20 of dialysis care.

21 MS. BURKE: So we have generic, not specific?

22 MS. RAY: That's correct, because that is based on

1 a sample of patients. I will see what is out there that  
2 looks at hospital-based and freestanding and will report  
3 back to you in April.

4 MS. BURKE: That would be great. Thanks. And I  
5 would also appreciate understanding more fully what the  
6 difference is moving from acquisition price to sales price.

7 MS. RAY: Sure. I think the issue with the  
8 average acquisition payment data is that the IG collected it  
9 in 2003, so it represents the negotiating patterns as of  
10 2003, so I would presume it's pretty accurate even now in  
11 2005. The concern here is as you go out over time -- the IG  
12 doesn't have to go out and collect it again for these top 10  
13 drugs, so what probably will happen is, if the Secretary  
14 continues to use it, I would guess that the Secretary would  
15 probably just keep increasing it by the producer price index  
16 or some other update proxy. So if negotiating patterns do  
17 change then that 2004 data won't reflect --

18 MS. BURKE: Let me tell you my fairly simplistic  
19 concern, and there may be no basis for this concern, is when  
20 I hear sales price I hear the opportunity for sales, the  
21 price that is essentially charged, to increase, if there's  
22 every incentive to do so. So I'm trying to understand -- I

1 understand your point about some data is going to be updated  
2 and some data is not. What I'm trying to anticipate is to  
3 what extent is there going to be an impact in either  
4 direction for a price increase because we will pay it? And  
5 whether this leads towards a behavior on the part of the  
6 negotiation where there is suddenly no inhibition on -- the  
7 price was 10, now it's going to be 20, because in fact what  
8 Medicare is saying is they're going to pay for the sales  
9 price.

10 I just want to understand whether there's an  
11 incentive in either direction, depending non the term that  
12 we use or the data that we use, that will suddenly provide  
13 an opportunity for price hikes solely as a result of the way  
14 we calculate what those numbers are going to be, if there's  
15 no inhibition. That's what I want to make sure I  
16 understand. I understand your desire for absolutely more  
17 current data. That goes without a doubt. I just want to  
18 understand what the difference is in this impact.

19 DR. MILLER: Joan, you may need to help us out  
20 here. Your fundamental concern, most attached very much to  
21 the average wholesale price in which that was a sticker  
22 place, nobody paid it. What the average sales is supposed

1 to represent -- and there is where I want Joan here -- is  
2 the transaction price net of discounts.

3 DR. SOKOLOVSKY: Let me start by saying your  
4 concern about Medicare paying the price, whatever the price  
5 might be, is well taken, but well taken on both sides.  
6 Average sale price is not the price. It is the data that  
7 manufacturers must report to CMS every quarter on their  
8 returns for each drug that they sell, net of discounts.

9 DR. MILLER: So it's supposed to be a transaction  
10 price, and it's supposed to be kind of like an acquisition  
11 cost, but the source of the data and the frequency of the  
12 data is what drives us more in --

13 MS. BURKE: What is the difference? Where we get  
14 it or who gives it to us?

15 DR. MILLER: That is certainly --

16 MR. HACKBARTH: So the sales price comes from the  
17 manufacturer. The acquisition cost comes for the provider  
18 of the services; is that right?

19 MS. RAY: That's correct.

20 MR. HACKBARTH: So what I hear being said, and  
21 correct me if I'm wrong, is that there's an existing  
22 mechanism for collecting the data from the manufacturer.



1 Right now there's just an every once in awhile survey to be  
2 collected from the provider. So if we were to use -- they  
3 seem logically to produce similar results, and in one case  
4 we have got an easy mechanism and the other case it's a  
5 harder mechanism.

6 MS. BURKE: So the assumption is -- I mean, we  
7 collect information from hospitals on a variety of things  
8 all the time, so if we wanted to we could say, we want your  
9 acquisition price. But our presumption is because there's  
10 so little difference between them that we can assume going  
11 forward that having done one you'll get the other; that  
12 there is no difference?

13 DR. SOKOLOVSKY: There are limitations in both  
14 sets of data. They should return very similar numbers. The  
15 limitations are different for each set of data, but I think  
16 the most important thing is that there is a mechanism in  
17 place to regularly, each quarter, collect data.

18 DR. REISCHAUER: But the real issue is that under  
19 both there is an incentive of the sort that Sheila is  
20 referring to, and the question is what we do about that. It  
21 would be one thing if this were a drug that was widely used  
22 by other people, but they're pretty specialized and not sold

1 in other settings.

2 MS. DePARLE: You mean an incentive to not be  
3 truthful about the transaction.

4 DR. REISCHAUER: No, but why should the center  
5 care? You double the price, I get 3 percent on top of  
6 whatever double the price is, so I'm indifferent.

7 MS. DePARLE: That's why we've recommended  
8 bundling.

9 DR. SOKOLOVSKY: I think part of the incentive  
10 driving ASP -- to go to ASP was the very fact that these are  
11 not drugs with huge markets, and that if the price went way  
12 beyond what Medicare will pay, the providers would have  
13 reason to balk. We're paying based on the previous  
14 quarter's ASP, so if they buy it that quarter --

15 MR. HACKBARTH: You're saying the lag effect holds  
16 down --

17 DR. REISCHAUER: As long as it doesn't rise by 3  
18 percent, or whatever the margin is, over the course of the  
19 period.

20 DR. SOKOLOVSKY: Nancy can tell you about dialysis  
21 facilities, but I can certainly tell you that in the  
22 oncology market the providers are very worried and concerned

1 about when a drug goes -- when they can't get a drug for  
2 below that ASP plus six -- and it happens upon occasion --  
3 that is a problem for them. They don't say, we'll make it  
4 up next quarter.

5 MS. BURKE: I can appreciate that and I think  
6 that's exactly right, but I'm not sure it's exactly an  
7 analogous situation because in this case we're paying a  
8 composite rate, plus we're paying for the drug plus 3  
9 percent. The oncology guys are in a slightly different  
10 scenario, where I suspect they are a little more price  
11 sensitive. This is a more captured environment where you're  
12 essentially paying for everything that surrounds it, and the  
13 composite presumably pays for whatever the costs are that  
14 are incurred in providing the service. The oncology guys I  
15 think are in a slightly different scenario, but I certainly  
16 understand your point.

17 But it is what it is. We're going to pay the  
18 price plus 3 percent.

19 MR. HACKBARTH: Let me ask this. So we're paying  
20 a price based on ASP, which is an average. If an individual  
21 provider of dialysis services actually acquires it for less  
22 than that, they benefit directly; is that right?

1 MS. RAY: Even now under the average acquisition  
2 payment that is the case, yes.

3 MR. HACKBARTH: So there is a PPS-like incentive  
4 to negotiate hard, try to acquire for less, which then would  
5 flow into the calculation of the average. So it's not a  
6 straight cost reimbursement system. There is a reason to  
7 bargain.

8 MS. BURKE: Good to know. I guess what would be  
9 helpful to understand is what does that -- in reality, do we  
10 know what those boundaries look like? If it is an average -  
11 - I didn't understand that essentially what you're getting  
12 is you're getting an average. You're getting a reported  
13 amount from a pharmaceutical company, correct, on what their  
14 average price?

15 DR. SOKOLOVSKY: Weighted average.

16 MS. BURKE: Do we know what those -- this is a  
17 fairly select group of drugs from a fairly select group of  
18 manufacturers. How big are those margins when they're  
19 talking to a fairly limited number of dialysis? Are there  
20 huge variations in how much they negotiate depending on  
21 volume?

22 MS. RAY: We're going to try to report back to you

1 in April about the purchasing strategies by different types  
2 of facilities.

3 MS. BURKE: Because it's not like they've got a  
4 lot of other choices.

5 MS. RAY: But I want to say what the IG found.  
6 Again, I'll repeat this, is that the average acquisition  
7 cost of the four national chains was ASP minus 6 percent.  
8 For a sample representing all other freestanding facilities  
9 they, on average, paid ASP plus 4 percent. So the payment  
10 rates that are in effect in 2005 is the weighted average  
11 acquisition payment, weighting it basically 70/30.

12 MR. HACKBARTH: We have time for maybe one more  
13 quick --

14 MS. DePARLE: You may have answered this in the  
15 exchange you had with Glenn and Mark at the beginning, but  
16 on the add-on payments does our recommendation contemplate  
17 going back to the policy that CMS articulated last summer  
18 and reconfiguring it so that -- remember that the hospitals  
19 which get paid on a cost basis for those drugs also got the  
20 add-on spread to them? So would we contemplate fixing that  
21 are not? I wasn't clear.

22 DR. MILLER: Not dollar for dollar. We're trying

1 to look across a set of payments here, the \$4, how we're  
2 paying on drugs, how we're making those changes. We'll come  
3 back to you with a net effect. But we're not trying to --  
4 and if this is an objective we need to talk about it. We're  
5 not trying to take all of those dollars and put them back  
6 into the freestanding environment.

7 MS. DePARLE: Others may not agree but when you  
8 presented last year the proposed regulations about the MMA,  
9 that was something I thought -- and we discussed it in here.  
10 I don't know how people feel, but I didn't think that was  
11 appropriate that they spread it across both the hospital  
12 facilities and the freestanding.

13 MR. HACKBARTH: There is a trade-off, isn't there?  
14 If you value a single rate without regard to type of  
15 provider I think you, by definition, have to spread it. If  
16 you say that we're going to keep all these dollars on the  
17 freestanding side you've basically said we're never going to  
18 a single rate. I think that's the trade-off.

19 MS. DePARLE: We can talk about this later. I  
20 don't see why you couldn't go from where they were last  
21 summer, where CMS was, only give it to the facilities from  
22 whom it came, the add-on, and then take the next step

1 towards a level playing field without going back there.

2 MR. HACKBARTH: I guess the other logical option  
3 is to level up and say, we're going to allow the  
4 freestanding to keep these additional dollars and to the  
5 extent that the hospital-based would end up with a lower  
6 rate we will add an increment on to theirs so we get to a  
7 level playing field. But if you have a budget neutrality  
8 constraint, the only way to get to a level playing field is  
9 to spread the add-on dollars across both types.

10 As Mark points out, in other cases there are  
11 pluses and minuses. That's why I asked earlier it would be  
12 good to know what the net impact is.

13 MS. DePARLE: I think we'll see that. I need to  
14 think about this some more but I at least felt that that  
15 policy last summer wasn't fair, and I hear you about where  
16 we're trying to get to.

17 On broadening the payment bundle, are we saying --  
18 I know this was the recommendation in 2001, but are we  
19 saying that we think CMS should broaden the bundle in the  
20 demo, or that -- are we just reiterating what we said  
21 before?

22 MS. RAY: We are reiterating what we said before.

1 And I think this would take congressional action, not just -  
2 - I don't think CMS would have the authority to do this by  
3 themselves, but just reiterating that, for it to be done.

4 MS. DePARLE: Although one thing you would assume  
5 we might learn from the demo is whether this works or not  
6 and what the bundle should be and should not be. At least  
7 on those lines one thing that you talked about last year at  
8 some point that I thought was very compelling was about some  
9 of the things that aren't covered now, or maybe not as much  
10 as we think they should be, such as the nutritional  
11 products. I don't know what you're thinking of as far as  
12 how it should be broadened, but I thought some of those  
13 things you said were compelling and that we should, if we're  
14 going to do this other report in June that we should  
15 reiterate some of them.

16 Also the vascular access point. I don't know the  
17 extent to which that is encouraged in the way that we pay  
18 right now, but it should be, I think we all agreed, so I  
19 would like to see that in there as well.

20 DR. MILLER: It isn't encouraged, and I think the  
21 contemplation here when we say this again is that we are  
22 saying all those things again. I think probably the one



1 pause -- it's not that we're against the demonstration at  
2 all. I think there's some sense of a need to move faster on  
3 this; is that --

4 MS. RAY: Yes, I think that's it. If it gets into  
5 place and going in 2006 it goes for three years, but then it  
6 has to be evaluated and so forth. I think like other  
7 payment systems, this one I think might be ready to just  
8 have the payment bundle broadened. I think that there needs  
9 to be a lot of careful thought about what services go into a  
10 broader bundle. Again, I think, is it just dialysis  
11 services or is it services to treat a dialysis patient?  
12 That would get into the nutritional care which is related to  
13 dialysis, as well as vascular access, as well as perhaps  
14 some care related to diabetes. Cardiac reasons is the  
15 biggest cause of death among dialysis patients, and can we  
16 think about the broader bundle and perhaps ways to include  
17 other services that a dialysis patient needs into it? That  
18 would potentially have the long range implication of  
19 improving quality.

20 DR. NELSON: I was just going to say, next month  
21 if you could dilate a little more on the case-mix adjustment  
22 that would help us understand better the rationale for a

1 broader bundle and also for standardizing payments across  
2 sites.

3 MR. HACKBARTH: Thanks.

4 We will have a brief public comment period. You  
5 all heard my commitment to the commissioners so please make  
6 your comments very brief. Thanks.

7 MS. SMITH: I will make them brief. I just wanted  
8 to make one comment. I'm Kathleen Smith from Fresenius  
9 Medical Care and I can talk as fast as Dr. Wakefield so I'll  
10 be quick and brief.

11 I just wanted to address the question of impact  
12 that you asked, Glenn. I'm not clear exactly whether you're  
13 talking about the going forward impact or not, but the  
14 starting point impact I think would be the impact that the  
15 final rule had on payment for both provider settings. In  
16 the final rule, the impact on freestanding providers was a  
17 negative 0.4 percent, and the impact on hospital-based  
18 providers was positive 6.6 percent, so we're starting from  
19 that.

20 Also, when you talk about eliminating the four-  
21 dollar differential in the hospital-based, hospital-based  
22 outpatient dialysis treatments are apparently 15 percent of

1 the total treatments done each year, so you're taking \$4  
2 from 15 percent and talking about spreading that out over  
3 the other 85 percent, so that certainly dilutes the impact  
4 in that shift.

5 The other comment is, what's a little bit  
6 confusing here is, because the legislation went part way to  
7 a broader bundle, not quite but this intermediate stage,  
8 which has called a great deal of confusion, such that we  
9 have the composite rate and add-on payment for the previous  
10 AWP margin protection that was intended for the  
11 freestanding, but we also have a separate stream of revenue  
12 from the separately billables going forward still. So we're  
13 talking about both the payment for the drugs going forward  
14 as well as what's in that add-back piece. I just wanted to  
15 say that it seemed we were talking sometimes about one and  
16 sometimes about the other here this afternoon.

17 Thank you very much. Safe trip home, everyone.

18 MR. MAY: Thanks. Don May from the American  
19 Hospital Association. Just two quick comments. First on  
20 the ESRD issue.

21 We do believe there are differences between  
22 hospital-based ESRD services and the freestanding services,

1 not only in the patients they're seeing but also in where  
2 they're located. I was just on the phone the other day with  
3 a hospital in Camden, New Jersey who talked about the case  
4 mix in his facility, the comorbid conditions of the patients  
5 the come in there, and that there aren't any freestanding  
6 facilities nearby to take them.

7           As you weight the options of combining a composite  
8 rate and getting rid of the differential, we've historically  
9 been in favor of larger bundles. I think though the case-  
10 mix tool needs to be -- we need to be thoughtful of the  
11 case-mix tool. The case-mix tool that was put in place for  
12 RUGs is woefully inadequate, and look how many years -- that  
13 was put in place in 1998. Look how many years we've gone  
14 without refinement of that. So I think before we start to  
15 tinker with the differential -- we know there are cost  
16 differences in those patients -- we need to think about how  
17 quickly that can be fixed if that case-mix tool isn't where  
18 it needs to be.

19           The second issue around CAH hospitals. Just want  
20 to reiterate the comments we heard today from Mary and Nick  
21 and Ray. I think they really made some good points. I  
22 think the key thing I learned listening to the presentation

1 was how important the CAH program is to these rural  
2 facilities, and really had the PPS systems, both for  
3 inpatient and outpatient and actually also for SNF, have  
4 really failed small rural facilities and isn't working. It  
5 really shows the need for a program that protects access in  
6 rural America. I think that this program is succeeding in  
7 what it was meant to do and it's very important, and just  
8 encourage you to remember that as you develop the report and  
9 finalize that.

10 Thank you.

11 MR. HACKBARTH: Thank you all. See you next  
12 month.

13 [Whereupon, at 12:32 p.m., the meeting was  
14 adjourned.]